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ABSTRACT

The first part of this five-part report on Acquired Immunodeficiency Syndrome (AIDS) in Connecticut defines the public health challenge presented by AIDS and describes the roles of community-based AIDS organizations, the Connecticut state government, and the Governor's Human Services Cabinet in addressing that challenge. Part II, "The AIDS Problem in Connecticut," presents statistics on AIDS in the state and looks at transmission categories, the distribution of cases by locality, trends in the rate of increase, the prevalence of infection, AIDS in minorities, variation by age, AIDS in children, and projections. Part III, "Human Needs in the AIDS Epidemic," considers the roles of education and intervention in preventing the spread of human immunodeficiency virus (HIV) infection; examines the delivery of health care and social services; looks at the financing of AIDS-related care; and discusses AIDS counseling and testing, surveillance, confidentiality, discrimination, and infection control. Part IV, "AIDS Policy Principles and Recommendation for State Action," presents principles and recommendations in the areas of concern identified in part III. Part V, "Connecticut State Government Response to AIDS," presents summaries of AIDS-related activities conducted through January 1, 1989 by numerous Connecticut state agencies. Appendices comprising about half of the document contain tables and figures, a summary of testimony at the public forums on AIDS, state personnel guidelines, the State Board of Education guidelines, the Centers for Disease Control guidelines, and a report to the General Assembly by an AIDS task force. (NB)

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AIDS IN CONNECTICUT:
RECOMMENDATIONS FOR A STATE POLICY RESPONSE

REPORT OF THE GOVERNOR'S HUMAN SERVICES CABINET
TO GOVERNOR WILLIAM O'NEILL

MAY, 1989

Anthony V. Milano
Chair, Governor's Human Services Cabinet
Secretary, Office of Policy and Management

CG022393

Prepared by

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I. INTRODUCTION

With the AIDS epidemic, the citizens of Connecticut face a disease which is not only incurable and fatal, but one that engenders much stigma and fear. This harsh reality presents an unprecedented public health challenge which requires fashioning adequate and appropriate responses to AIDS that are guided by compassion, tolerance and a recognition of the dignity of each individual citizen.

To meet this challenge, policy makers, agencies and organizations in both the public and private sectors must work together. They must educate all citizens about AIDS and the behaviors that will transmit the AIDS virus so as to overcome unwarranted fears and curb its spread. They must also improve access to health care and social services.

A. THE ROLE OF COMMUNITY-BASED AIDS ORGANIZATIONS

It is impossible to discuss the State's response to AIDS without acknowledging the contribution and role of community-based AIDS organizations which have been on the vanguard of the response to AIDS in Connecticut as well as the rest of the country. These local groups and agencies, staffed largely by volunteers, fill a critical need by providing information, AIDS education and direct support services to person with HIV infection, their families and friends.

Many of these organizations, such as the AIDS Projects, formed in the early and mid 1980s, initially developed within the gay community to provide services specifically to gay men. Eventually, these programs were extended to the general population and to anyone at risk for becoming infected with HIV.

Most community-based AIDS organizations which have been operating quality programs with few paid staff and a core of dedicated community volunteers have played an enormous role in developing essential services on a community level which include AIDS risk reduction and prevention services. They also provide a wide range of support services for people who are HIV infected, their families and friends such as individual, family and group counseling, "buddy" systems, referral networks, hotlines, housing assistance and placement, entitlement education and assistance (e.g. Medicaid, and Social Security), transportation and training programs for volunteers and care givers. Many of these services are not available through the traditional health care system and are currently being provided exculsively by community-based AIDS organizations in the state.

B. STATE GOVERNMENT RESPONSE TO AIDS

The state of Connecticut is committed to meeting the AIDS challenge with a coordinated interagency effort, in consultation with other governmental and private sector groups, so that the Connecticut response to the AIDS epidemic is comprehensive, clearheaded, broad-based and effective.

Governor William A. O'Neill has already taken action to fashion such a response. In September, 1985, Governor O'Neill issued Executive Order 13, which designated the Department of Health Services as the lead agency to work with other state agencies to determine appropriate policy in regard to persons with AIDS.

In addition, the Governor's Human Services Cabinet chose AIDS as one of its top priorities at its first meeting in September, 1987. The Cabinet, composed of the Commissioners of 14 state human services agencies, is chaired by Anthony V. Milano, Secretary of the Office of Policy and Management. Among its goals are to ensure the development of coordinated human services policies and a coordinated delivery of human services programs in Connecticut.

The Governor's Human Services Cabinet has sought to provide, in conjunction with the Department of Health Services, the necessary leadership on AIDS so that policy development is coordinated on the myriad of issues facing the state of Connecticut today and in the future. This coordinated interagency effort, in consultation with other governmental and private sector groups, has resulted in the development of the recommendations for a state government response to AIDS described in this report.

Ultimately, this effort seeks to assure that the needs, concerns and dilemmas faced by people with AIDS in Connecticut are resolved and that the State of Connecticut meets the challenge of responding to the AIDS epidemic for the benefit of all its citizens.

C. THE GOVERNOR'S HUMAN SERVICES CABINET ADDRESSES AIDS

At its January, 1988, meeting, the Governor's Human Services Cabinet received reports from state agencies detailing their AIDS-related activities and projections for future programs (see Chapter V for state agency reports which have been updated to January, 1989). In addition, the Cabinet identified the major policy questions facing the state of Connecticut on the issue of AIDS.

THE AIDS WORK GROUPS

The Governor's Human Services Cabinet formed four work groups to address the AIDS policy questions in four general issue areas: 1) AIDS prevention:

education and intervention; 2) financing of AIDS health care and social services; 3) AIDS treatment and service delivery, and 4) counseling and testing, surveillance, confidentiality, discrimination and infection control.

Staff at the Office of Policy and Management, working with Commissioner Frederick G. Adams and his staff in the AIDS Section of the Preventable Disease Division at the Department of Health Services, coordinated the AIDS work groups. The work groups were charged to develop AIDS Policy Principles and Recommendations for State Action that address:

- The State's Leadership Role: In what ways can the state provide leadership to respond to the AIDS epidemic? How could its policies and practices be models to the private sector and other governmental bodies?

- State's Other Roles: How should the state respond to AIDS in its role as an employer, a provider of direct care and a provider of funds to private agencies who deliver services?

- Coordination: What mechanisms should be in place to coordinate policy development and the delivery of services on AIDS in each policy area?

- Research Needs: What data and research is needed now and in the future to assist state policy development and planning in each area?

The four AIDS work groups, described below, began meeting in January, 1988. In June, 1988 the AIDS Treatment and Service Delivery Work Group and the Financing of AIDS Health Care and Social Services Work Group were merged due to the interdependence of service delivery and financing issues.

1. AIDS Prevention: Education and Intervention Work Group

Chair: Gerald N. Tirozzi, Commissioner of Department of Education

Participants: Department of Education, Department of Health Services, Department of Human Resources, Department of Children and Youth Services, Connecticut Alcohol and Drug Abuse Commission, Department of Higher Education

Policy areas: Prevention of HIV transmission through education and intervention; state's responsibility to educate its employees, health care providers, social services professionals, and those individuals under its care or jurisdiction.

2. Financing of AIDS Health Care and Social Services Work Group

Chair: Stephen B. Heintz, former Commissioner of Department of Income Maintenance (now Commissioner of Economic Development).

Participants: Department of Income Maintenance, Department of Health Services, Office of Policy and Management, Commission on Hospitals and Health Care, Commission on Long Term Care.

Policy areas: Responsibility of the public and private payors, including insurance, in financing the cost of HIV-related health care and social services.

3. AIDS Treatment and Service Delivery Work Group

Chair: Michael F. Hogan, Commissioner of Department of Mental Health.

Participants: Department of Mental Health, Department of Health Services, Department of Mental Retardation, Department of Income Maintenance, Department of Human Resources, Department of Correction, Department of Children and Youth Services, Commission on Long Term Care, Office of Policy and Management, Connecticut Alcohol and Drug Abuse Commission, Commission on Hospitals and Health Care.

Policy areas: Needs of persons with HIV-related illnesses for an array of health care and social services including medical treatment, long term care, housing and support services; the health care and social service needs of special populations (i.e. children, women, gay men, minorities); the care to be provided for persons with HIV infection in state operated programs, including foster care for children and facilities for mentally ill, mentally retarded and adult and juvenile offenders.

4. Counseling and Testing, Surveillance, Confidentiality, Discrimination and Infection Control Work Group

Chair: Larry R. Meachum, Commissioner of Department of Correction.

Participants: Department of Correction, Department of Health Services, Connecticut Alcohol and Drug Abuse Commission, Department of Children and Youth Services, Department of Mental Health, Department of Mental Retardation, Department of Human Resources, Commission on Human Rights and Opportunities and Office of the Attorney General.

Policy areas: Screening of general population or sub-groups; HIV counseling and testing; preserving confidentiality of HIV test results or diagnosis; surveillance; measures to reduce potential and actual discrimination against persons with AIDS, ARC or who are HIV infected and persons perceived to be in any of these groups.

Each of the work groups developed AIDS Policy Principles in their respective issue areas which were endorsed by the Cabinet at its May, 1988, meeting. The Policy Principles are statements of goals that, if achieved, will mean a coordinated, comprehensive response to AIDS in Connecticut.

In July, 1988, the Cabinet issued an Interim Report on AIDS that presented the AIDS Policy Principles. Public Forums were held in Hartford and New Haven in September, 1988, to receive comments on the Cabinet's Interim Report on AIDS. Citizens, organizations and groups in Connecticut commented on the AIDS Policy Principles and suggested recommendations for state action. A summary of public testimony and a list of those who testified are presented in Appendix B.

After reviewing testimony received at the AIDS Public Forums, final Recommendations for State Action, which flow from the AIDS Policy Principles, were presented to the Cabinet by the work groups in January, 1989.

THE CABINET'S RECOMMENDATIONS TO THE GOVERNOR

The content of this final report of the Governor's Human Services Cabinet represents 18 months of research, education, collaboration and careful deliberations by members of the Cabinet and their staff, as well as input from private sector organizations and the public.

Chapters II and III provide a context for the Cabinet's AIDS Policy Principles and Recommendations for State Action. Chapter II describes the nature and dimension of the AIDS epidemic in Connecticut using current epidemiologic data on AIDS and HIV infection. Chapter III presents the human face of the AIDS epidemic, describing the needs and ethical dilemmas created by the spread of the AIDS virus.

In Chapter IV, the AIDS Policy Principles and the Recommendations for State Action are presented. AIDS Policy Principles form the philosophical underpinnings of how to address the AIDS epidemic in the state and the Recommendation for State Action provide a blueprint for moving forward with a coordinated, consistent and effective state government response to the AIDS epidemic.

Finally, in Chapter V, state agency summaries of the AIDS-related activities through January 1, 1989 are presented.

A Note on Terminology

In the early years of the epidemic, the term "AIDS" was used to refer to those who were diagnosed with specific opportunistic infections and cancers. As more was learned about this immune deficiency syndrome, it became clear that AIDS was not the entire disease, but rather it was one stage of a condition caused by the Human Immunodeficiency Virus (HIV).

For the purposes of this document, the term "HIV infection" will be used to indicate the full continuum of the illness, including the initial infection that causes the body to produce antibodies to HIV, the asymptomatic stage, the stage classified as AIDS-Related Conditions (ARC), a term that is falling out of use, and the stage that the U.S. Centers for Disease Control classifies as AIDS. The term "HIV infection" will be used in this document except in those cases where a reference is being made specifically to AIDS or ARC. For more information on the stages of HIV infection, see "Medical Aspects of AIDS", Chapter III.

II. THE AIDS PROBLEM IN CONNECTICUT

AIDS (Acquired Immune Deficiency Syndrome) is an acquired illness of the immune system which reduces the body's ability to fight certain types of opportunistic infections and cancers. The Human Immunodeficiency Virus (HIV) is the cause of this illness. HIV is transmitted through sexual contact -- anal, vaginal or possibly oral intercourse -- and by direct exposure to infected blood or blood products, especially the sharing of needles in intravenous drug use. In addition, babies of women who are HIV infected may be born infected with the AIDS virus as it can be transmitted before or possibly during birth. HIV has not been shown to be transmitted by any other means. People cannot get AIDS from casual contact. Even family members living with HIV-infected people before and after those people developed AIDS have shown no infection with HIV unless they have had sexual relations or blood contact through needles or other means with an HIV infected person.

The Human Immunodeficiency Virus (HIV) causes a spectrum of disease which includes AIDS. After becoming infected, individuals may feel healthy and develop no symptoms for many years. Some individuals go on to develop symptoms such as weight loss, chronic fatigue, lethargy, swollen glands, persistent diarrhea, low-grade fevers and oral thrush. Persons are diagnosed as having AIDS when they have developed one or more specific opportunistic infections or rare cancers.

For reporting purposes, only cases of AIDS, as defined by the U.S. Centers for Disease Control, are required to be reported to public health officials in Connecticut. Among persons officially diagnosed as having AIDS in the U.S., 50 percent die in the first year and over 80 percent die within three years. Survival time will probably increase with new therapies. Specific opportunistic diseases must be present in order for the case to be diagnosed officially as AIDS and to be reported to the U.S. Centers for Disease Control, the Connecticut Department of Health Services, and local health departments. In general, the diseases include unusual forms of bacterial, fungal and viral infections, and rare cancers. Dementia and severe weight loss caused by HIV are also defined as AIDS.

AIDS is, and will continue to be, a major public health problem in Connecticut and nationally. Our national ranking is currently 16th among the reporting states and areas for total cases reported. Connecticut's contribution to the national total of AIDS cases has remained constant at 1.1 percent to 1.2 percent. As of December 31, 1988, there had been a cumulative total of 1,021 cases and 604 deaths due to AIDS in Connecticut, with 417 people with AIDS still living. The total number of adult cases as of that date was 988, with 587 deaths. The number of pediatric cases (less than 13 years of age at diagnosis) was 33, with 17 deaths.

Males were predominant among reported AIDS cases (80%). Female cases have gradually increased in recent years; in 1988, 26 percent of the diagnosed cases of AIDS were female. Cases of AIDS usually occur among young adults, with 67 percent of diagnosed cases between the ages of 20 and 39. Fifty-three percent of all cases were Black or Hispanic. (See Appendix A, Table 1 and 2.)

A. TRANSMISSION CATEGORIES

Analysis of AIDS cases in Connecticut and nationally indicates that the most frequent modes of transmission are sexual activity or intravenous (IV) drug use. HIV is exchanged in the blood and in some bodily fluids (e.g. semen). As of December 31, 1988, 40 percent of all Connecticut cases have been bisexual or gay males. Thirty-seven percent of adult AIDS cases in Connecticut have had a history of IV drug use. Another seven percent of cases have been gay and bisexual males who are also IV drug users. A total of 51 percent of all Connecticut cases have been either directly or indirectly linked to IV drug use. (See Appedix A, Table 2.)

The epidemiology of AIDS in Connecticut differs from the national pattern in several important ways. Minorities have been disproportionately represented among cases. More than half of all cases in Connecticut (53%) have been either Black or Hispanic. Intravenous drug users make up a larger proportion of cases in Connecticut than nationally, 37 percent as opposed to 20 percent, and are gradually becoming the primary source of new cases. The Connecticut Alcohol and Drug Abuse Commission (CADAC) estimates that there are 40,000 - 50,000 intravenous drug users residing in Connecticut.

The majority of heterosexual cases who did not use IV drugs have had sexual partners who used drugs intravenously. Correspondingly, women and children, most often the sexual partners and offspring of IV drug users, represented a larger proportion of Connecticut cases than they did nationally: 20 percent as opposed to 9 percent for women and 3.2 percent as opposed to 1.6 percent for children. Seventy-eight percent of all cases in women have been IV drug users or sexual partners of IV drug users. Of the 33 pediatric cases in Connecticut as of December 31, 1988, 88 percent have been linked to IV drug use in one of the parents.

B. DISTRIBUTION OF CASES BY LOCALITY

The AIDS epidemic has spread throughout Connecticut. As of December 31, 1988, all counties and 111 (66%) of the 169 municipalities in Connecticut have had reported cases. The majority of AIDS cases, however, are concentrated in certain population centers. Analysis by county shows that New Haven and Fairfield counties have had the highest incidence of AIDS cases per 100,000 population. Eighty-nine percent of Connecticut's cases lived in New Haven, Fairfield, or Hartford counties at the onset of their illness. The towns with most cases, New Haven (215), Hartford (155) and Bridgeport (83), are all located within these counties. (See Appendix A, Table 3.)

C. TRENDS IN THE RATE OF INCREASE

Overall, the rate of increase in reported AIDS cases in Connecticut has slowed somewhat. At the same time, however, numbers of reported cases have increased from year to year and trends for the state indicate that numbers of reported cases will continue to rise (see Appendix A, Tables 4A and 4B). Annual incidence rates show increasing rates for the state as a whole, with particularly rapid increases for males compared to females, and Blacks and Hispanics compared to Whites.

The relative contribution of gay and bisexual men and IV drug users to newly occurring AIDS cases has been changing over time. Cases in heterosexual IV drug users have increased steadily in number from the first diagnosed case in 1981. Since 1986, the number of cases in IV drug users has been approximately the same as the number of gay and bisexual men. (See Appendix A, Table 8.)

D. PREVALENCE OF INFECTION

Nationally, one to 1.5 million persons are estimated to be currently infected with the virus that causes AIDS. The Connecticut Department of Health Services estimates that 12,000 to 36,000 persons are currently infected with HIV in Connecticut. From an analysis of overall rates, populations in Connecticut are estimated to have varying levels of HIV infections. Data on the prevalence of HIV infection in selected populations in Connecticut show rates of infection as high as 13 percent among persons with a history of IV drug use who have been tested at drug treatment centers. Gay and bisexual males visiting Connecticut's community counseling and testing sites have HIV antibody seroprevalence rates of 11.6 percent. Overall, clients of Connecticut's counseling and testing sites, with many types of risk behavior, have lower rates, ranging from 4.7 percent to 7.2 percent (see Appendix A, Table 5). For Connecticut's populations with high risk behavior, rates of infection are appreciably lower than comparative populations in New York City, where three years ago IV drug users were reported to have been 68 percent seropositive and gay men were found to have been 65 percent seropositive.

Previously, most populations for which information on rates of HIV infection has been available were self selected and did not, therefore, accurately represent the general population or groups of special interest. Rates of HIV infection for such populations have, nevertheless, provided preliminary information from which some broad comparisons can be made.

Special seroprevalence surveys are currently being conducted by the Department of Health Services to overcome problems with data collected for purposes other than monitoring of HIV infection.

For example, a special study of newborn infants has been designed to provide measures of HIV infection rates for women of child-bearing age. All newborn infants in Connecticut have blood specimens drawn for pheylketonuia (PKU) screening. During the fall of 1988, these specimens were also tested for HIV antibody as a pilot for Connecticut's newborn survey. Preliminary results from this blind survey show that 0.23 percent of 5,589 infants tested were found to be positive. Although this level of infection is relatively low, it is a matter of some concern since these women and some of the newborns may progress to full-blown AIDS. These rates are higher than that of female military recruits in Connecticut (0.04).

E. AIDS IN MINORITIES

Among AIDS cases, Black and Hispanic persons have been represented in disproportion to their numbers within the state. According to the 1980 census, Blacks in Connecticut constituted seven percent of the total population and Hispanics four percent. However, among AIDS cases, 37 percent of all cases have been Black and 16 percent have been Hispanic. Together, Black and Hispanic persons have constituted more than half of all cases. Sixty-seven percent of all female adults and 91 percent of all cases in children are either Black or Hispanic. Among states with the highest AIDS incidence rates in the nation, Connecticut has had particularly high rates among minority populations for both males and females.

The statewide over-representation of Blacks and Hispanics among AIDS cases also holds true for New Haven, Hartford, and Bridgeport -- towns with the most reported cases. In New Haven, for example, 66 percent of cases are Black while 31.9 percent of the town's population in 1980 was Black. In Bridgeport, the proportion of Hispanic cases was 33.7 percent although the proportion of Hispanics in the town is 21 percent.

For Black and Hispanic cases of AIDS, intravenous drug use is even more common a mode of HIV transmission than it is for Whites. Sixty-three percent of Black cases and 66 percent of Hispanic cases have a history of drug abuse, while 19 percent of White cases have this history.

The magnitude of the AIDS epidemic among minorities in Connecticut can also be demonstrated through data on HIV infection rates from several sources. Data collected on new military recruits by the Department of Defense show a much higher incidence in Blacks and Hispanics than Whites. Black male recruits have been 12 times, and Hispanic recruits 10 times, more likely to have been infected than White recruits (see Appendix A, Table 6). Data on clients of drug treatment centers in Connecticut have shown seroprevalence to be twice as high among Black and Hispanic clients as among White clients enrolling for treatment of intravenous drug use. At alternative counseling and testing sites, Blacks had approximately three and Hispanics approximately five times the infection level of Whites (see Appendix A, Table 7).

F. VARIATION BY AGE

The incidence of AIDS has varied considerably by age. The most sexually active groups have had the highest rates. People between ages 20 and 49 have also been most likely to have used drugs intravenously. Sixty-seven percent of Connecticut's reported cases were diagnosed between the ages of 20 and 39. Although there have been no cases in the group ten to 19 years of age, cases in the next oldest age group (20 to 24 years old) were likely to have become infected as teenagers. Teenagers have had particularly high rates of sexually transmitted diseases which, like HIV infection, are also transmitted through sexual intercourse. Rates of new AIDS cases are increasing most dramatically for the 20 to 49 year-old age group.

G. AIDS IN CHILDREN

Connecticut has had a significant incidence of AIDS in children. Although Connecticut has contributed about 1.2 percent of all AIDS cases in the United States, it has contributed between two and three percent of the cases in children under age 13. As of December 31, 1988, 33 cases of AIDS in Connecticut children have been reported, but there are many more who are infected with HIV.

It is estimated that, over the next several years, from 100 to 300 children per year will be born to women who are infected with HIV. About 30 percent of those children will continue to show evidence of infection with HIV after the first year of life. The other 70 percent are assumed to have had passively acquired maternal antibodies to HIV rather than true infection with HIV. They will not suffer any HIV-related illness. Of the 30 percent who are HIV antibody positive after the first year, one third will develop AIDS by four years of age. Information on the entire course of disease in children is not available. Therefore, it is predicted that each year there may be between 30 and 90 children born who are truly HIV infected, and that between ten and 30 may be diagnosed as cases of AIDS within four years of birth.

H. PROJECTIONS

Results of a U.S. Centers for Disease Control/San Francisco Department of Health Cooperative Study suggest that 35 percent of HIV infected persons will develop AIDS within seven years of infection and that five to ten percent of people infected with HIV will develop AIDS each year between the second and seventh years of infection. It is unclear what the ultimate prognosis may be. However, it is clear that a large portion, perhaps including most HIV infected persons, will become ill.

By the end of 1989 in Connecticut, the Department of Health Services estimates that there will be a cumulative total of approximately 2,000 cases since the beginning of the epidemic. At the end of 1990, approximately 2,900 cases will have been diagnosed.

By 1991, it is estimated that AIDS will be one of the top five causes of years of potential life lost in Connecticut and nationally. In addition, it will outstrip automobile accidents as a cause of death nationally in 1991.

III. HUMAN NEEDS IN THE AIDS EPIDEMIC

AIDS and Human Immunodeficiency Virus (HIV) infection have become a tragic reality for the men, women and children who are living and dying with this disease in Connecticut. Their plight is overwhelming -- AIDS remains fatal; there is no cure or vaccine. Because of public fear and prejudice, although unwarranted and undeserved, people with HIV infection are subjected to societal disdain, harassment and discrimination. It is expected that many more Connecticut citizens will become ill with AIDS-related conditions in years to come.

To respond to human needs in the AIDS epidemic, Connecticut policy makers face four challenges. First, further spread of HIV, the cause of AIDS and other HIV-related illnesses, must be controlled. Second, health care and social services for those persons who are HIV infected must be provided now and in the future. Third, financing must be available to pay for needed health care and social services. Finally, the issues of counseling and testing, surveillance and infection control must be addressed clearly and with consistency, so that transmission of the virus can be reduced in a climate that protects against discrimination and preserves confidentiality of information and individual rights.

This chapter of the report describes the nature of each of the above challenges and provides a context for the AIDS Policy Principles and Recommendations for State Action developed by the Governor's Human Services Cabinet and presented in Chapter IV.

A. PREVENTING THE SPREAD OF HIV INFECTION: EDUCATION AND INTERVENTION

With no effective cure or vaccine for AIDS at this time, prevention is the only significant weapon to curb this epidemic in the short and long run.

United States Surgeon General C. Everett Koop has stated:

> It is the responsiblity of every citizen to be informed about AIDS and to exercise the appropriate preventive measures... With proper information and education, as many as 12,000 to 14,000 people could be saved from death by the beginning of the next decade.

HIV infection is preventable because it is most commonly transmitted through consensual behaviors that can be modified. These behaviors include coming into direct contact with the virus through intimate sexual relations with a HIV infected person or exposure to the blood of an infected person, largely through sharing of needles when using intravenous drugs. Prevention of HIV infection can be accomplished through education and intervention.

EDUCATION

Everyone needs information about HIV infection and its transmission. AIDS education should focus on changing the high risk activities of all individuals, enhancing decision-making abilities and fostering healthy practices and behavior. At the same time, the needs of persons with varying social, cultural and ethnic identities should be taken into account. To ensure meaningful communication, AIDS information and education should be tailored for specific cultural or ethnic groups. To ensure cultural sensitivity, community people and programs should be involved in the planning and provision of AIDS education programs.

Those who have been at highest risk for contracting and spreading the AIDS virus are sexually active gay and bisexual men who do not practice safer sex, intravenous drug users who share needles, sexual partners of infected persons and children born to HIV infected women. Minorities, women and children have been disproportionately represented among AIDS cases in Connecticut. Those with special needs for AIDS education are described below:

Women - Although HIV infection is an issue of concern for all women, the vast majority of women who are HIV infected are of reproductive age and have a high likelihood of transmitting the infection to their offspring during pregnancy. The spread of HIV among these women is directly related to the increasing number of infants born with HIV infection in Connecticut over the past several years. As a consequence, there is a strong need to inform and educate women about AIDS and a need for outreach efforts to reach these women.

Children and Adolescents - Children and adolescents are in particular need of accurate information about AIDS and HIV infection so that they are motivated to protect themselves and make informed choices about their present behaviors and the behaviors they might adopt in the future.

Minorities - Because HIV infection has had a large impact on Black and Hispanic communities, AIDS education efforts that address the issue of high risk sexual behavior as well as intravenous drug use must be sensitive to cultural issues and differences. Development of strategies to reach minority populations is a crucial piece of any program aimed at curbing the spread of the AIDS virus among IV drug users.

Gay and Bisexual Men - As a result of the high number of cases of AIDS among gay and bisexual men, there is a need for continued outreach, education and support that is sensitive to the gay community, that speaks to the needs of those who engage in gay and bisexual behaviors but do not identify with the gay community, and that is culturally sensitive to the gay and bisexual men who are Black or Hispanic.

Populations Under the Care, Custody, and Control of the State - Residents of state operated 24-hour facilities may be at risk for transmitting or contracting HIV infection as a result of engaging in high risk behaviors. These persons need to be informed about the nature of AIDS and how HIV is and is not transmitted so that they will be able to modify any high risk behaviors.

INTERVENTION

Interventions that prevent the spread of HIV infection are necessary when individuals continue to practice behaviors that place them at risk of becoming HIV infected or of spreading the virus. Interventions to curb sexual transmission of HIV include providing information about how to have safer sex and distributing condoms.

Interventions are also needed to prevent the spread of HIV infection among intravenous (IV) drugs users. Transmission of the virus through IV drug use is becoming more frequent, both nationally and in Connecticut. According to the Connecticut Department of Health Services, as of December 31, 1988, 51 percent of all Connecticut AIDS cases have been either IV drug users, or are sexual partners or children of IV drug users. The highest incidence of AIDS cases are primarily concentrated in urban areas: New Haven, Hartford, Bridgeport, Stamford, Norwalk, Danbury, and Waterbury.

There are three possible ways for the AIDS virus to be transmitted that are related to intravenous drug use:

- Blood transmission - by sharing contaminated needles, syringes or cookers.

- Sexual transmission - being a sexual partner of an intravenous drug user.

- Perinatal transmission - being born to a woman who is an intravenous drug user or the sexual partner of one.

Characteristics of drug users vary depending on the type of drug used, the geographic area where the drug user lives (i.e. urban versus suburban), the social class of the drug user and the local drug culture. The drug user may be a teenager, athlete, artist, businessperson, or prostitute.

Cocaine is used more often in social settings than is heroin. Therefore, when taken intravenously, it is even more likely to be associated with needle sharing than is heroin. Because the effect of cocaine is shortlived, small doses are injected frequently. Presently, there is no effective substitute drug treatment for cocaine addicts that is similar to methadone maintenance for heroin addicts. Some cocaine addicts are not IV drug users, but they are still at risk for HIV infection. For example, some crack (a concentrated form of cocaine that is smoked) addicts trade sex for crack and this high risk sexual behavior puts them at risk for HIV infection.

AIDS Intervention For IV Drug Users - Two Starting Points

There are two distinct and potentially conflicting starting points to any discussion of interventions designed to prevent the spread of AIDS among IV drug users. They are:

- Drug Abuse Intervention Efforts - The goal is to curb drug abuse. These efforts are aimed at getting IV drug abusers off drugs.
- AIDS Intervention Efforts - The goal is to curb the spread of AIDS. These efforts prevent IV drug users from becoming infected with and spreading the AIDS virus through risky behaviors (e.g. sharing needles).

These starting points may conflict in some situations. For instance, whereas law enforcement efforts designed to reduce and prevent IV drug use can also curb the spread of AIDS, they will, in some cases, drive drug users underground and make them less receptive to AIDS intervention efforts. On the other hand, some potentially effective strategies to reduce the spread of AIDS among IV drug users (such as distribution of clean needles to curtail sharing of dirty needles) may not discourage IV drug use.

It is important to clarify a common misconception about drug addicts. Contrary to popular belief, drug users are willing and capable of protecting themselves against AIDS. Research indicates IV drug users are not unconcerned about AIDS and that practical approaches to AIDS risk-reduction (such as education and distribution of bleach) can be effective in this population.

Interventions to slow the spread of HIV infection among IV drug users include: a) drug abuse treatment; b) street outreach providing education, bleach, and condoms; and c) needle exchange programs.

a. Drug Abuse Treatment

Access to drug treatment is a cornerstone for controlling the spread of HIV infection among IV drug users. Research in New York City conducted by Donald Des Jarlais of the New York State Division of Substance Abuse Services found that more than 50 percent of the drug users seeking drug treatment cited fear of AIDS as one of the reasons for entering treatment.

Currently, the state funds four different types of drug treatment programs:

1. Detoxification - These programs involve the management of clients who are withdrawing from the effects of drug abuse through medical means under the supervision of trained personnel. Treatment is most often provided on an inpatient basis in order to ensure the safety and well-being of clients who are experiencing potentially life

threatening withdrawal symptoms.

2. Residential Drug Free Treatment (3 to 18 month rehabilitation) - These programs provide live-in facilities and drug treatment and rehabilitation services to individuals in need of a 24-hour a day supportive environment.

3. Outpatient Drug Free Treatment - These programs provide treatment to clients who have sufficient social and emotional support to participate in treatment on an outpatient basis. The client attends the treatment unit according to a prescribed schedule for services that include individual, group, and family therapy as well as supportive services.

4. Outpatient Methadone Treatment - These programs provide treatment specifically for heroin abusers who meet specified admission criteria. The client receives prescribed doses of methadone and participates in treatment according to a prescribed schedule for services that include individual, group, and family therapy as well as supportive services.

Efforts to change drug abuse behavior must proceed with the understanding that addictive behavior is not often changed without specific drug treatment. Therefore, expanding the number of program slots for the treatment of IV drug users is an important part of any plan to prevent HIV transmission.

All drug treatment approaches should include information and counseling on blood, sexual, and perinatal transmission of HIV, on availability of family planning services, and on availability of voluntary HIV antibody testing. Programs should provide necessary nutrition and health education to HIV infected clients.

Unfortunately, a significant number of IV drug users will not go into drug treatment even if it is available. In addition, drug treatment has no strong proven success rates. Because of recidivism rates in drug treatment programs and the considerable amount of time treatment may take, drug treatment should be viewed as a long range strategy. In order to address the immediate problem of curbing the spread of HIV infection among IV drug users, this approach should be used in conjunction with other options, like street outreach providing AIDS education, bleach and condoms.

b. Street Outreach Providing Education, Bleach, and Condoms

Street outreach programs can be an effective means of providing AIDS education and risk-reduction information to IV drug users who are not in treatment. When educated effectively about AIDS, IV drug users can be motivated to modify their behavior or to enter drug treatment.

Outreach involves using street workers, preferably recovering addicts, to make direct, person-to-person contact with IV drug users not in treatment. The purpose of these contacts is to educate drug users on the proper procedure for disinfecting syringes using household bleach and on safer sex practices. This type of program provides an excellent opportunity to distribute condoms, small bottles of bleach, and AIDS prevention information. Street outreach also provides an opportunity to encourage and refer drug users to drug treatment programs.

In the month of January, 1989, state and federal funded street outreach workers in Connecticut made 485 contacts with IV drug users. During this same month, 1,000 bleach packets and 2,000 "clean your works" information pamphlets were distributed. In addition, 75 IV drug users were referred to treatment. Although street outreach programs are encouraged to dispense bleach and condoms, as well as information, the Connecticut Alcohol and Drug Abuse Commission does not make such distribution a requirement of state funding.

c. Needle Exchange Programs

These programs exchange dirty needles for clean needles at no cost to participants. A clean needle is given out for every dirty needle returned, so that no additional needles are added to the street.

Proponents of needle exchange argue that high rates of HIV infection are present in many states that require prescriptions for needles. Connecticut is currently one of eleven states which require a prescription for the purchase of hypodermic needles. It is also illegal in Connecticut to be in possession of drug paraphernalia, including syringes and needles.

A New Jersey survey which asked addicts why they shared needles found that a major reason why IV drug users share drug "works" is because it is a crime to carry drug paraphernalia. Sixty-two percent of the drug users surveyed said that the only way they would stop sharing needles is if they could buy the works legally without a prescription and carry them around.

Although there are needle exchange programs operating in Europe, there are currently only two small pilot programs in the United States located in New York City, New York and Tacoma, Washington. Because these pilot programs are new and small, data or findings that will be useful in identifying their successes and problems will not be available for some time.

B. THE DELIVERY OF HEALTH CARE AND SOCIAL SERVICES

MEDICAL ASPECTS OF AIDS

AIDS is not a single disease; it is a syndrome caused by the Human Immunodeficiency Virus (HIV), and the course of the illness varies widely. Originally, only people who had a narrow spectrum of opportunistic infections and cancers were identified by the U.S. Centers for Disease Control (CDC) as having AIDS. Now it is understood that the disease needs to be more broadly defined and, increasingly, AIDS is being viewed within a continuum of HIV infection.

The continuum of HIV infection begins with a person becoming infected with the virus. After becoming infected, individuals may feel healthy and develop no symptoms for many years. Some individuals go on to develop symptoms such as severe weight loss, night sweats, persistently swollen lymph glands, or persistent diarrhea. Persons experiencing these symptoms are sometimes labeled as having AIDS-Related Complex (ARC) because the symptoms do not fit the CDC definition of AIDS. However, the term "ARC" is falling into disuse. Once an individual develops specific opportunistic infections or cancers (such as pneumocistis carinii pneumonia and Kaposi's Sarcoma), or is diagnosed as having AIDS Dementia Complex, they are considered to have a full-blown case of AIDS.

Due to the broad range of diseases affecting persons with HIV infection, treatment of any two individuals will vary. Relapses of certain opportunistic infections are common and a number of infections require ongoing treatment. Numerous body systems may be affected. They include the skin, the mouth, the gastrointestinal tract, the eyes, the lungs, the kidneys, the neurologic system, the blood and the heart.

Neurological complications in a person with HIV infection can be serious. Ten percent of persons with AIDS have neurologic signs before other symptoms appear. When given psychological tests, 45 percent of persons who are HIV infected but without symptoms achieve abnormal results. Thirty to 60 percent of those with AIDS ultimately get AIDS Dementia Complex.

The vast majority of children with HIV infection in Connecticut acquired their disease before birth from their infected mother, who typically has a history of being an intravenous (IV) drug user or being a sex partner of an IV drug user. Accurate diagnosis of AIDS among children is difficult because the symptoms initially are less clearly discernible than they are in adults.

AIDS in children is characterized by recurrent bacterial infections affecting a range of body systems, malnutrition caused by gastrointestinal problems, and anemia. Up to 50 percent of children with AIDS have some type of neurological problem. Infection of the central nervous system results in failure to thrive, central nervous system dysfunction and developmental disabilities.

NEEDS OF INDIVIDUALS INFECTED WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV infection is a chronic, disabling and terminal illness. Like persons with other types of chronic and disabling illnesses, those with HIV infection eventually require an array of medical, social and support services. Nearly all those who are HIV infected need education and counseling, emotional support services, and outpatient care services. All persons with full blown AIDS and about a third of those identified as having ARC may need some combination of intermittent hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) levels of care and community-based home care and support services. As is true with all persons, individuals with HIV infection prefer to lead as productive lives as possible while managing their illness and prefer to reside in a setting that allows them a maximum degree of independence and dignity.

While persons with HIV infection have many of the same service needs as persons with other chronic conditions, they also differ in significant ways, and these differences present challenges to the current health care delivery and financing system. Below is a list of those issues that individually may apply to other diseases but together distinguish AIDS from other chronic and disabling illnesses:

Fatal disease - Among persons diagnosed as having AIDS, 50 percent die within the first year and over 80 percent die within three years. Survival time will probably increase with the advent of new drug therapies.

Communicable disease - Although one cannot "catch" HIV infection through casual means, but must have direct exposure to infected blood or body fluids, many people are fearful of possible exposure. The general public as well as providers of care must be educated so they understand how the disease is and is not transmitted, their real (as opposed to perceived) risk for infection, and how to protect themselves when providing care.

Social stigma - Persons with HIV infection not only suffer physically, but they also suffer as a result of the social stigma attached to this illness. Unlike most other illnesses, the plight of AIDS sometimes does not elicit a compassionate response. This can leave those with HIV infection alone, without the necessary support systems of family and friends. Discrimination can cause them to lose their jobs and housing and may be a barrier to their access to needed services.

Disenfranchised groups - In addition to the social stigma attached to being HIV infected, many of those who are infected also suffer from multiple social stigmas as a result of being either a gay man, an IV drug user, a prostitute, poor, Hispanic or Black. These people traditionally experience difficulty gaining access to the health care system.

Strikes young adults - The vast majority of persons with HIV infection are relatively young, primarily between the ages of 20 to 49. This is usually a very productive and vital time of life. Those with AIDS may have young children and families that are dependent upon them.

Provider resistance - High levels of education and training are required to help providers of care work effectively with HIV infected persons. Medical and social service staff in many areas of the state have not received sufficient training in dealing with AIDS and in confronting their own anxieties and fear. Insufficient staff training and fear of AIDS has prompted some agencies to refuse to work with HIV infected persons.

High cost of care - The cost of care to persons with HIV-related illnesses is often higher than similar services to persons with other types of illnesses due to the intensive level of technical and support services required. Difficulties with reimbursement for the higher costs of care to persons with AIDS-related conditions discourages some agencies from serving this population. Neither Medicaid or private insurance rates cover actual patient care costs, and some insurers do not cover personal care or care in a community setting.

Uninsured - Many of those who are HIV infected do not have health care insurance. These individuals are usually uninsured because they are unemployed or work at jobs that do not offer medical benefits. Those that do have health care insurance through their employers may lose this coverage when they stop working as a result of this illness or may exceed insurance coverage maximums.

Reliance on public financing - Medicaid covers a disproportionate percentage of AIDS-related costs. As of June, 1988, Medicaid has paid claims on almost 50 percent of all AIDS-related costs in Connecticut. In contrast, Medicaid only paid claims on nine percent of hospital-related costs for all categories of illnesses combined.

Loss of housing - Persons who are HIV infected are at risk of losing their housing due to discrimination or loss of income or are already homeless. Without an identified home setting, a person cannot receive services from a home care program.

Overuse of acute care facilities - After a bout of an acute episode of illness, persons with AIDS may remain in the hospital longer than is medically required because they may not have a home to return to or have someone to help care for them in their homes. In addition, there are no intermediate care or skilled nursing facilities in Connecticut that currently accept persons with AIDS.

While any one of the above examples of problems specific to HIV infection may also hold true for other chronic or disabling conditions, it is the sum of these differences that make HIV infection a major challenge to the current health care system. AIDS is not different because the infections and illnesses associated with it are new. It is different because the needs of a growing number of persons with HIV-related illnesses are placing unavoidable demands on the health care delivery system at its weakest points, raising levels of awareness about existing issues of access, reliance on institutional care, and coordination and financing of health care.

Psychosocial Needs

The psychosocial aspects of HIV infection make this illness particularly complex. Persons with AIDS experience a high degree of anxiety and depression, frequently accompanied by rejection and a sense of loss. Many individuals who have HIV-related illnesses either lose or do not have family and friends to support and care for them. They also may lose their jobs, medical insurance, and housing and become impoverished as their illness progresses.

Black and Hispanic individuals with HIV infection often have particular needs as a result of cultural and language differences. A recognition and understanding of these needs is required by care providers so that they can offer effective psychosocial counseling and support to minorities with HIV infection and their friends and families.

At every stage of HIV infection, including the asymptomatic stage, there is need for counseling and support services in order to assist the person cope with the stresses of the illness. This means that providers of care need preparation, training, and ongoing support so that they can effectively educate and support their patients and clients.

The needs of the family and other caregivers must be recognized and addressed so that they can provide the support and understanding necessary to help the person with HIV infection. Specifically, families and friends of persons with HIV infection may need the following: assistance in combatting the stigma often associated with the disease; health care professionals to recognize the role that family and friends play in the maintenance and well being of the person with HIV infection; access to and financial support for counseling and other mental health services; and access to community and home-based care.

Special needs

Certain groups of HIV infected persons have specific treatment and care needs which differ from those of other population groups and are described below:

Women with HIV Infection - Poor women, particularly poor minority women, and their children who are in need of HIV-related care face many obstacles. Many may be uninsured or not be able to afford coverage for their children; there may not be physicians or programs readily available to serve them; transportation to the health care setting and child care may not be available. Minority women are in particular need of access to health care providers that are sensitive to their cultural backgrounds and needs.

HIV infected children - Almost all of the children with HIV infection in Connecticut acquired it before or possibly during their birth to an HIV infected woman. A special problem unique to many children with HIV infection is the fact that one or both parents may be unavailable to care for them due to their own AIDS-related illness or drug addiction. HIV infected children require the whole range of acute, chronic, and supportive care services, including home care, day care, hospitalization, out-patient treatment and support services for mothers and care givers that are specifically tailored to children. Furthermore, they may require foster family care or community-based residential care, so that they do not remain in the hospital after it is no longer medically necessary.

Adolescents - Adolescents are most likely to receive health care in their pediatrician's office, in school health clinics, in sexually transmitted disease clinics, and family planning clinics. When discussing a problem related to sexual behavior, especially gay sexual behavior, adolescents are most likely to seek care from those service agencies offering confidentiality.

Gay and bisexual men - Gay and bisexual men with HIV infection generally have better health and higher incomes than other individuals who become HIV infected. However, like many people who are at risk for HIV infection, gay and bisexual men have difficulty obtaining access to existing health care services because of discrimination, lack of provider sensitivity to gay health issues, and provider attitudes towards homosexuality.

Gay or bisexual Black and Hispanic men who engage in high risk sexual behaviors are less likely to obtain health or support services from organizations which are perceived as gay-related and more are likely to seek information, guidance and care from those community-based organizations which have traditionally served their respective cultural communities.

Minorities - Infection with HIV is a particularly severe public health problem in Black and Hispanic communities in Connecticut. Providing care and support services to Blacks and Hispanics with HIV infection is complicated by a variety of socioeconomic factors. Minority communities often include a large proportion of people who are poor, unemployed, lack health care insurance, are in poor health, and lack access to health care services.

Drug Abusers - Intravenous drug abusers pose substantial problems for the health care system because many are poor, uninsured, in generally bad health, or homeless. IV drug users are generally distrustful of traditional health care services and often do not comply readily with treatment recommendations. Persons who are HIV infected and addicted to drugs may have difficulty finding family and friends to help care for them when they become disabled and are in particular need of housing and community-based services.

SERVICE DELIVERY

Since HIV infection is a chronic illness, characterized by intermittent or continued bouts with opportunistic infections which are often debilitating, persons with AIDS-related illnesses require a range of health care and social services. Despite this need for a variable range of services, acute care hospitals persist as the central treatment site for most persons with HIV-related illnesses. Many receive their initial diagnosis in the hospital and are generally readmitted several times for invasive diagnostic tests and follow-up treatment of recurrent infections. This is particularly true in areas that have not developed outpatient AIDS resources such as clinics, ambulatory services and home care services that meet the needs of persons with AIDS and are willing to serve them.

The increasing incidence of HIV infection, especially in major metropolitan areas, will affect the overall hospital bed capacity and the utilization of many hospital services. This is already becoming a concern in New York City, where the number of persons hospitalized with AIDS-related illnesses increased by one-third during in 1987, taking up beds that were not estimated to be needed for persons with AIDS until 1990. This situation has contributed, in part, to longer waits at many hospitals for elective surgical and medical admissions.

While hospitals are facing the growing demand for HIV-related acute care, there is an increasing need for a range of home and community-based services to assist those with HIV infection when they are between acute episodes of illness.

The following array of services should be considered in any system of care developed to address the AIDS epidemic in Connecticut:

General Acute Care Facilities - An acute care hospital provides a broad range of 24-hour inpatient care with full medical staff and support available. Basic services include medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary.

Skilled Nursing Facilities - A skilled nursing facility provides continuous nursing care and supportive care to patients who may not be acutely ill but who primarily require rehabilitation or skilled nursing care on an inpatient basis.

Intermediate Care Facilities - Patients in an intermediate care facility do not require continuous skilled nursing care. They may be ambulatory or non-ambulatory, and require some level of monitoring and on-going assistance with daily activities and maintenance. Their need for skilled nursing care is intermittent.

Community Care Facilities - Community care facilities provide non-medical residential care in residential facilities, board and care homes and group homes. These facilities provide housing, meals and supervision or assistance with daily activities such as eating, bathing, dressing, toileting and taking medications.

Home Health Care - Home health care services enable patients to remain in their home while receiving ongoing medical monitoring and support services to meet their daily living needs. These services include skilled nursing care, homemaker services, personal care services, companions, social work services, home delivered meals, hospice care, and respite.

Community Care - Child and adult day care facilities offer medical, psychological, rehabilitation, social, nutritional and educational services.

Outpatient Services - Hospital outpatient clinics, community health centers, dental clinics and mental health and counseling programs provide services in the community to meet the medical and psychosocial needs of individuals who are ambulatory.

Foster Family Care - Specialized foster care for children.

Alternative Housing - Alternative housing situations include non-medical residential care (housing, meals, assistance with activities of daily living).

Support Services - Support services that help maintain an individual in the community include case management, therapeutic drug treatment such as AZT (Zidovudine), transportation, recreation, legal services, pastoral counseling, income maintenance, and emergency medical services. Adequate and ongoing education and training of health and social service providers is also necessary to support the treatment and care of persons with HIV infection.

Substance Abuse Treatment - Substance abuse treatment can be provided on a residential, outpatient and home-care basis. Programs include drug detoxification, methadone maintenance and drug rehabilitation.

The AIDS epidemic challenges the entire health care delivery system. It highlights and magnifies such difficult issues as access to services by those who are poor, gay, Black or Hispanic, or those who do not have any private or public sponsored medical care insurance; the nursing shortage; and the tendency of the health care financing system to reimburse for institutional care rather than community-based care. Because individuals who are HIV infected appear throughout the health care system and require a full array of acute and community-based services and resources, the entire health care delivery system must be able to respond. It is not feasible nor practical to develop a separate system for those with HIV infection. However, within the existing system of health care services, it may be appropriate to develop special programs, facilities or residences for persons with special needs. Whatever crises occur in the health care delivery and financing system as a result of the AIDS epidemic will affect all those in need of health care, not just those with HIV infection.

Case management services can improve the quality and cost-effectiveness of HIV-related care by promoting better coordination of services and greater use of alternatives to hospital care. In any one community, there may be a wide range of health care and social service providers involved with the treatment and care of persons who are HIV infected. However, the care of any one individual is often fragmented and individual providers may not be aware of, or coordinating with, the existing services, providers, and resources that are available. Due to the unpredictable and varied care needed by persons with HIV infection and the difficulty encountered in accessing services in any service delivery system, case management services are needed. Optimally, case management should operate at the community level and each case manager should be able to cross institutional boundaries in the course of assisting any one individual.

Responding to the needs of persons with HIV infection is both a private and public sector responsiblity. Since the state is seldom a direct provider of health care services, the burden of this responsibility falls heavily on the private health care delivery sector.

HOUSING

Affordable, adequate and appropriate housing is one of the most critical needs of people with HIV infection in Connecticut. A 1986 survey by the Department of Health Services found that five out of 26 individuals hospitalized for an AIDS-related illness were inappropriately retained in the hospital because of problems finding appropriate housing. In 1987, a survey by the Connecticut AIDS Residence Program, in conjunction with the American Hospital Association, determined that 20-25 percent of all persons with AIDS needed housing upon release from the hospital.

Reasons why people with HIV infection have significant problems in obtaining and keeping appropriate housing include:

Financial hardship due to HIV-related illness: When persons with HIV infection lose their jobs because of discrimination or because they are no longer medically able to work, they may not be able to pay a mortgage or rent. In addition, in order to qualify for Medicaid to pay for health care costs, applicants are required to "spend down" their assets to a minimal level.

Housing discrimination: Because many landlords, tenants and family members have an unrealistic fear of contracting HIV infection, persons with HIV infection are sometimes evicted from their homes or have difficulty renting or buying housing. While this discrimination is illegal, persons with HIV infection, who must first concentrate on their medical and psychological needs, often do not have the time or energy to pursue legal remedies once evicted or refused housing. Instead, they will seek new housing which will be difficult to locate because of the financial hardships they face as well as potential discrimination by other landlords or tenants.

Need for home care support: The illnesses faced by persons with HIV infection can be debilitating and may leave people unable to care for themselves without some continous level of medical or social services or supervision. If an individual can no longer care for him or herself and cannot arrange for appropriate home care services, housing that provides supportive help (e.g. medical care, social services, homemaker services, nursing care) may be required. The need for supportive housing is further compounded by the fact that there are currently no nursing homes in Connecticut which will accept AIDS patients.

Children with HIV infection also have very specialized housing needs. While babies who are HIV antibody positive and are no longer able to remain with their birth parents often live in the hospital, all of these children in Connecticut are currently in appropriate foster care placements, due largely to the extremely effective work of the Department of Children and Youth Services (DCYS).

History of Connecticut's Role in Providing Housing for Special Populations

Over the past 15 years, Connecticut, like other states across the country, has been moving away from institutional care of specialized populations (e.g. mentally ill, mentally retarded, physically disabled) to community residential facilities that provide the least restrictive setting for the client.

In this process, state agencies charged with providing care for each specialized population have established a continuum of housing alternatives. For example, in deinstitutionalizing its population, the Department of Mental Retardation has regional centers, group homes (where four to eight people with mental retardation lived communally with staff in a community setting), and scattered site apartments (with one, two or three individuals living in apartments with supportive services provided).

Scattered site apartments for people with mental illness or mental retardation as well as other populations reflect a growing consensus in

Connecticut's human services system that alternative residential models which emphasize supported independent housing are needed to supplement (not to replace) traditional residential programs (e.g. group homes). This policy has underlied the development, in recent years, of residential models which maximize the independence of special needs populations.

Today, community residential facilities of various types are funded by the state for the following populations:

- Traumatic Brain Injured
- Mentally Ill
- Mentally Retarded
- Substance Abusers
- Criminal Justice Clients
- Blind and Hearing Impaired
- Pregnant Teens

Housing for people with HIV-related illness is being developed within this historical framework. In 1987, the Connecticut General Assembly authorized the Department of Human Resources to establish a pilot program in two communities to provide housing for persons with AIDS (P.A. 87-533). Private sources throughout the state are also financing development of housing for people with HIV-related illness. Residences that are being developed under these programs include both group residences and scattered site apartments.

Existing Models for Housing for Persons with HIV Infection

The following continuum of housing alternatives for adults with HIV infection includes several different models to meet varying needs. It does not include medical care placements (e.g. Intermediate Care Facilities, Skilled Nursing Facilities).

Housing in the Private Market - Some persons with HIV infection can secure housing for themselves and their families in the private market. This is possible because they can afford to pay market rates for housing and are either physically well enough to live on their own or are able to arrange for home care services.

Subsidized Apartments - In this model, subsidized apartments are provided for persons with HIV infection and their families who are financially unable to pay market rates for housing. This model includes apartments in scattered sites, as well as apartments in a multi-family structure where not all units in the building are designated for people with HIV infection. There is also subsidizied housing available under the federal Section 8 program for individuals or families with low incomes.

Subsidized Apartments with Supportive Services - Subsidized apartments are provided for people with HIV-related conditions and their families and supportive services are arranged by a case manager who makes periodic home visits and arranges for necessary services. This model is appropriate for persons with HIV infection who are financially unable to pay market rates for housing and need someone to provide support services, but are generally well enough to maintain their own household. This model is currently being used in Hartford.

Subsidized Housing in Multi-Family Dwellings with Supportive Services - Subsidized housing is provided in a multi-family structure in which all apartments are for persons with HIV infection and their families. Case management is provided and supportive services are arranged by a case manager. This model provides an added degree of peer support for persons with HIV infection, while allowing them to maintain their own separate apartments.

Group Residences without On-Site Staff Supervision - This model is a group home which provides communal housing on a sliding fee scale, as well as mutual peer support for persons with HIV infection. Each group residence typically provides housing for four to eight persons with HIV infection. No staff are assigned to the premises, beyond periodic home visits by case managers. All medical and social services are provided outside the residence. Models for this type of program are being planned in Bridgeport and Fairfield.

Group Residences with On-Site Staff Supervision - This model is similar to the communal living arrangement above, but staff provide either 24-hour or part-time coverage of the residence. Staff may make meals, do home maintenance and coordinate outside medical and social services. Programs based on this model are planned for Stamford and New Haven.

Intravenous Drug User Residence - This group residence would provide both housing and drug treatment for intravenous drug users with HIV infection. A model has been designed for Bridgeport.

It is important to note that this continuum of housing alternatives does not include emergency homeless shelters as a housing option for persons with HIV infection. While a June, 1988 Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended the use of temporary overnight shelters to house persons with HIV infection, emergency shelters do not appear to be an appropriate setting for such people. Because emergency shelter populations evidence a significantly higher rate of certain infectious diseases than does the general public, persons with HIV infection, whose immune systems are weakened, may be at greater risk of obtaining infections or diseases at these shelters. Also, the clear intent of emergency shelters is to provide temporary accommodations until the residents find permanent housing.

C. FINANCING AIDS-RELATED CARE

There can be no doubt that the AIDS epidemic will have a significant financial impact on Connecticut's health care system. Total expenditures for AIDS-related care were $7 million in 1986. These costs are expected to increase dramatically in the next few years, rising to $50 million by 1991.

In Connecticut, the distribution of payors is radically different for AIDS-related care than it is for other health problems. Medicaid, the health insurance program for the poor, plays a far more important role in AIDS than it does in other illnesses. The Connecticut Medicaid Program is the single largest payor of AIDS-related care, funding approximately half of all AIDS-related charges in 1987. Private health insurance policies are the next largest payor, covering approximately one-third of the cost of AIDS care. The remaining AIDS charges, about 16 percent of the total, are funded by Medicare (1.9%), patients who pay for their own care (8.1%), and other sources (5.8%).

A May, 1987 Staff Paper from the Congressional Office of Technology Assessment reports that there is a sharp contrast between who pays for AIDS-related care in the United States and who pays for all other kinds of medical care. Their work, summarized in Table 1 below, revealed that in 1986, private insurers (18%) and the federally-funded Medicare program (2%) together paid for only one-fifth of all AIDS-related medical costs. By contrast, these two groups paid for nearly 66 percent of all medical costs. The funding gap

TABLE 1

United States, 1986: Payor Distribution -- AIDS & All Other Health Care Costs

	Private Insurance	Medicaid	Medicare	Other
AIDS-Related-Costs				
All AIDS Costs	18%	50%	2%	30%
All Other Health Care Costs				
Hospital	36%	9%	29%	26%
Physician	45%	4%	21%	30%

Source: "The Cost of AIDS and Other HIV Infections: Review of the Estimates"; Office of Technology Assessment; Staff Paper; May 1987.

created by the absence of Medicare and private insurance coverage has been filled almost exclusively by Medicaid, which pays for half of all AIDS-related health care costs nationwide.

THE ROLE OF PRIVATE INSURANCE

The lower rate of private insurance participation in AIDS health care financing is probably tied to the shift in the incidence of infection from gay and bisexual men to intravenous drug users. The latter group is more likely to be uninsured. Intravenous drug users, their partners and their children accounted for 55 percent of new AIDS cases in Connecticut in 1988.

Even for those members of the work force who contract AIDS, their employers' group insurance plans may not provide a financial safety net. Severe illness and/or employer discrimination often force people with AIDS to quit their jobs, a change which triggers the withdrawal of employer-paid medical benefits.

Lastly, there is evidence that private insurers are taking steps to limit their AIDS liability. Findings in a February, 1988 Staff Paper from the Congressional Office of Technology Assessment on AIDS and health insurance show that 86 percent of the insurers, Health Maintenance Organizations (HMOs) and Blue Cross/Blue Shield plans surveyed asked AIDS-related questions as a precondition to health care coverage. Of the companies that received AIDS-related claims, one out of four rejected at least 50 percent of these claims, having found that they represented a pre-existing condition.

In general, insurance companies may restrict expenses incurred from HIV-related claims by refusing to insure people with HIV infection who apply for individual health insurance policies as they may refuse to insure applicants with known health conditions such as heart conditions, cancer, or diabetes. Insurance companies may also exclude AIDS-related care as a covered service in individually underwritten or group health insurance policies. Connecticut does not prohibit health insurance companies from excluding AIDS-related care as a covered medical condition in new policies.

Insurance companies may require tests for HIV antibody as a condition of coverage for individual health insurance policies. Currently in Connecticut there are no laws or regulations prohibiting insurance companies from requiring an HIV antibody test as a condition of eligiblity for individual health insurance policies. However, Connecticut law and regulations do not allow private insurers from asking questions to applicants for insurance about "personal lifestyle" or prior testing for HIV infection.

It is important to note that an increasing proportion of employers in Connecticut are self-insuring rather than subscribing to a private insurance company. Self-insurers, who cover approximately 42 percent of those who receive health insurance through their employer, are not regulated by the State Insurance Commission and are also exempt from having to contribute to the state insurance risk pool.

Rejection of insurance claims after a diagnosis of AIDS is more difficult to track. Claims from persons with HIV-related illnesses may be getting rejected by Connecticut insurers, but, to date, the Connecticut Insurance Department has not received any such complaints from people with HIV infection against insurance companies.

THE ROLE OF MEDICARE

Medicare participation in AIDS care financing is extremely low compared to its major role in other health areas. The reason is that most people with AIDS die before they complete the approximately two and one-half year waiting period to become eligible for Medicare.

Under regulations recently published by the U.S. Department of Health and Human Services, AIDS and ARC were added to the list of diagnoses that confer "a presumptive disability determination" upon the individual applying for assistance. Medicare eligibility, however, only comes two years after the applicant receives the first cash payment under the Social Security Disability (SSD) program and the first SSD cash payment, comes at least five months after the initial AIDS/ARC diagnosis. Thus, few individuals so diagnosed survive the 29 months necessary to qualify for Medicare.

THE ROLE OF MEDICAID AND ITS IMPLICATIONS FOR CONNECTICUT

With Medicare out of the picture and private insurance playing an ever smaller role, Medicaid has emerged as the single largest payor for AIDS-related health care in the state--with troubling implications. As a matter of principle, this payor mix upsets the rough balance that has been struck between public and private sector participation in shouldering the nation's staggering health care costs. Private insurance underwriters must be encouraged to respond to the AIDS crisis in a positive way.

Reliance on Medicaid does not satisfy the important intragovernmental aspects of the AIDS epidemic. Medicare is funded entirely by the federal government while Medicaid receives 50 percent federal funding and 50 percent state funding. Although the Medicare program has already recognized the national scope of AIDS by placing the disease on its list of "presumptive disability" diagnoses, full federal participation in sharing the cost of the disease is effectively prevented by a Medicare regulation that does not account for AIDS mortality.

Placing the major financing of AIDS-related care with Medicaid, with its traditionally low reimbursement levels, also will create greater strains on the nation's health care system. Several studies have shown that Medicaid reimburses hospitals for only a fraction of the cost of caring for people with AIDS. As the AIDS epidemic spreads, dependence on Medicaid will both increase the financial strain on hospitals and other medical providers, and exacerbate existing pressures on state Medicaid budgets.

D. AIDS COUNSELING AND TESTING, SURVEILLANCE, CONFIDENTIALITY, DISCRIMINATION, AND INFECTION CONTROL

Throughout the country, few public policy issues in recent years have raised as much debate about confidentiality, discrimination and the state's responsibility to preserve the public's health than has AIDS. The Governor's Human Services Cabinet maintains that the response to the AIDS epidemic must be based upon traditional values of tolerance and respect for individual rights, dignity and worth and grounded in scientific knowledge and sound public health practice.

Much important work in Connecticut on the issues of AIDS testing, confidentiality and discrimination has already been done by the Public Act 87-527 Task Force to Review Research and Recommend State Policy on AIDS (see Appendix F). Dr. Frederick G. Adams, Commissioner of the Department of Health Services, chaired the Task Force. Its final report sets forth policy directions on these issues that have been extremely instructive to the Governor's Human Services Cabinet in the development of its AIDS Policy Principles.

COUNSELING AND TESTING

In considering different approaches to testing, it is helpful to clarify the types of testing:

Human Immunodeficiency Virus (HIV) Antibody Testing - A blood sample is tested to determine the presence of the HIV antibody.

Voluntary testing - An individual requests to be tested for the HIV antibody.

Mandatory testing and screening - Testing individuals or screening groups to determine HIV antibody status is required and an individual cannot decline the test.

Voluntary counseling and testing programs are offered at HIV counseling and testing sites funded by the Department of Health Services. There are two options:

Anonymous - The counselor does not know the client's name and all counseling records and laboratory specimens and results are coded in such a way that no information appears that could reveal the client's identity.

Confidential - The counselor does know the client's identity but may not disclose information about the client without a written release by the client.

Informed consent is a necessary prerequisite to HIV antibody testing.

The purpose of obtaining informed consent is to ensure that individuals are not coerced or threatened and that they fully understand the implications of the HIV antibody test, what it reveals medically and what it may mean personally. Informed consent, whether it is given orally or in writing, should be well-documented.

In regard to assuring informed consent of the tested individual, counseling and testing are inextricably linked. Counseling before the HIV antibody test is administered provides the basis for informed consent to the test.

Pre- and post-test counseling is also an important tool in AIDS education. Counseling provides the opportunity to educate individuals on a one-to-one basis about HIV infection and to encourage them to change those behaviors that put them at risk for AIDS and that may spread the virus. Thus, voluntary testing is an important adjunct to risk-reduction counseling for persons involved in high-risk behaviors.

HIV antibody testing without informed consent is also permissible in certain circumstances. HIV testing should be performed before use of donated sperm, organ, tissue and blood or blood products. Although donating one's organs, tissues or blood is voluntary, HIV testing before use of donations should be required. Blood drawn for another purpose may also be tested for HIV antibodies in seroprevalence surveys which use blind (unlinked) testing. In these surveys, the persons doing the HIV testing have no way of linking the test results to any individual and the individuals do not know they are being tested for the AIDS virus.

Mandatory testing of an individual solely to assess HIV status is not warranted except in limited circumstances and in accordance with established protocols. In such a situation, the decision to test should be made on a case-by-case basis and only after consultation with appropriate medical and administrative personnel.

Mandatory screening, which implies offering a test to a whole population to determine each individual's antibody status, is not warranted for the general population or any sub-group of the population, including high-risk groups. Reasons for not requiring mandatory screening include the following:

- Without guarantees of confidentiality and penalties for unauthorized disclosure, mandatory screening may lead to possible discrimination and force underground those most at risk of HIV infection;
- Mandatory screening of the general population will yield a larger percentage of false positives than will testing in a high-risk population;
- Antibodies to the AIDS virus may not appear for three to six months after infection. Thus, negative results may lull individuals into complacency or cause them to disregard the essential counseling message of AIDS prevention.

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- Mass screening is not cost effective. Since the U.S. Centers for Disease Control recommends that HIV antibody testing be accompanied by pre- and post-test counseling, mass screening would require significant additional resources in terms of staff and staff training.

Testing prior to providing any state operated or funded service or program or as a prerequisite for state employment is not warranted. Testing in either circumstance would not be useful nor serve a compelling purpose.

SURVEILLANCE

Surveillance of a disease is the collecting, analyzing and interpreting of public health data. Surveillance is done systematically on an on-going basis to study how the disease occurs and spreads through the population, especially to different sub-populations and geographic areas. Surveillance data is also essential to program planning and evaluation.

Reporting: Currently in Connecticut, AIDS, as defined by the U.S. Centers for Disease Control, is reportable to the Department of Health Services. Positive HIV antibody test results are not reportable.

Epidemiologic Studies: Special epidemiologic studies such as seroprevalence surveys are useful surveillance activities. Many seroprevalence studies use "blind testing." Blind testing refers to testing blood which has been collected for other purposes on which personal identifiers are removed. Individuals do not know they are being tested and the persons conducting the surveys have no means of linking test results to any individual. This achieves an unbiased sample in a manner that is ethical and does not compromise confidentiality.

Maintaining confidentiality in AIDS surveillance activities, including reporting and epidemiologic studies, is imperative in order that adequate data and information are available to monitor the disease while maintaining the privacy of individuals.

CONFIDENTIALITY

At the core of many controversial issues regarding HIV antibody testing is the concern that medical information about an individual may be disclosed to persons without authorization. This concern is understandable given the fact that many health care professionals will see a patient's medical records in the course of treatment and that confidentiality is difficult to maintain in medical records systems.

In the relationship between the patient and the health care professional, confidentiality of medical information, such as a diagnosis of HIV infection, ARC or AIDS, is essential to establishing a feeling of trust. The belief that a medical professional will not disclose confidential information encourages patients to share freely personal information about health topics as sensitive as sexuality and drug use. Furthermore, the guarantee of confidentiality will encourage individuals who may be at high risk for HIV infection to come forward for counseling and testing.

Equally important, a breach of confidentiality regarding an individual's HIV status or diagnosis, can, due to the fear of and stigma attached to AIDS that prevails in society, result in discrimination or social ostracism. That can mean the loss of a job or housing or denial of benefits or privileges. It can also mean harassment, denigration and a loss of privacy and human dignity.

Therefore, information about HIV counseling and testing or medical diagnoses should be kept confidential. Disclosure without the authorization of the tested person should only be allowed so that appropriate medical care can be dispensed or as necessary for compelling public health purposes. It should be clear that, if disclosure is to be without authorization of the individual tested, public health purposes must be truly compelling and not based on perceived or minimal risk of infection. Furthermore, information disclosed in these circumstances should be used in a legally and ethically defensible manner.

A key component to assuring confidentiality is that persons authorized to give or receive information about HIV infection should be made aware of their responsibility to protect confidentiality. Training should be developed to impart such information clearly and consistently.

Confidentiality is also a consideration in partner referral programs. The partner referral program now carried out by the Department of Health Services involves program staff informing partners whose names have been given to them voluntarily by a person who is HIV antibody positive. The partners can then be contacted. The identity of the infected person will not be disclosed to the partner at the time of contact and the confidentiality of the partners will be maintained. Partners will be referred to counseling and testing sites.

DISCRIMINATION

Discrimination against people with AIDS, ARC or HIV infection has become a major civil rights issue in the 1980s. The emerging interpretation of state and federal laws and regulations has been that people with AIDS, ARC, HIV infection or persons perceived to have these conditions are protected under civil rights afforded to people with physical disabilities. However, discrimination against HIV infected persons will not subside until there is effective public education. Fears and misconceptions surrounding AIDS, particularly issues about HIV transmission, must be addressed forthrightly for the public to understand and accept people with HIV infection.

The potential for discrimination against people with HIV infection has created intense public discussion about the confidentiality of medical information, medical records and the results of HIV antibody tests, since the inappropriate disclosure of such information may result in discrimination in housing, employment, services, and insurance.

INFECTION CONTROL

Infection control refers to measures taken in diverse settings which are sufficient to break the chain of the transmission of a disease and to prevent infection of a susceptible host. In the AIDS context, infection control means the measures taken to prevent transmission of HIV to a caregiver who comes into contact with blood and body fluids.

The AIDS epidemic has prompted renewed attention to and increased vigilance with regard to infection control procedures in health care and custodial institutions throughout the state. The risk of HIV infection to health care workers is small, and regular use of standard infection control procedures can safeguard against the rare circumstance that could lead to HIV transmission. But these precautions cost money, both in terms of educating workers and in providing them with protective equipment. Other health, safety, and social service professionals, such as police officers, emergency medical technicians, fire fighters, and correctional officers, are also concerned about their risk, raising many questions about the everyday performance of their duties.

The U.S. Centers for Disease Control, in its Morbidity and Mortality Weekly Report, August 21, 1987, Volume 36, Number 2S, and its update in Morbidity and Mortality Weekly Report, June 24, 1988, Volume 37, Number 24, set forth their recommendations for prevention of HIV transmission in health-care settings (see Appendix E). These recommendations stress universal blood and body fluid precautions, that is, treating the blood and body fluids of all persons as potentially infectious, because the HIV status of such persons may not be known.

Studies of health care workers have shown that risk of acquiring HIV infection during the course of their work is extremely small. The universal precautions are a sound general practice because health care workers are at risk of infection from a variety of agents, including Hepatitis B.

In Connecticut, the Department of Health Services has issued two sets of infection control guidelines, based on recommendations of the U.S. Centers for Disease Control. In addition, the "AIDS Guidelines for State Personnel", (Appendix C) promulgated by the Bureau of Personnel and Labor Relations in the Department of Administrative Services and the Department of Health Services, recommend that state agencies develop and make available to employees agency specific guidelines for health care delivery and handling of blood and body fluids.

IV. AIDS POLICY PRINCIPLES AND RECOMMENDATIONS FOR STATE ACTION

The Governor's Human Services Cabinet, through the efforts of its four AIDS work groups, has developed the following AIDS Policy Principles and Recommendations for State Action for consideration by Governor William O'Neill.

Adopted in May, 1988, the AIDS Policy Principles form the philosophical underpinnings of how Connecticut will address AIDS in a reasoned, responsible way on such critical issues as counseling and testing, finance and delivery of health care and support services, and efforts to prevent the spread of the AIDS virus. These Principles are intended to guide the State of Connecticut as a provider of direct care, a funder and payor of services and as an employer. It is intended that State agencies follow these Principles in making policy decisions regarding AIDS and establish protocols and procedures as needed so that the state's response to AIDS is consistent and coordinated.

In addition, the Cabinet's AIDS Policy Principles are meant as models for organizations and institutions in the private sector and other governmental bodies to consider and adopt as they respond within their own spheres to the AIDS epidemic.

Recommendations for State Action, which flow from the AIDS Policy Principles, provide a blueprint for moving forward with a coordinated, consistent and effective state government response to the AIDS epidemic. These recommendations were developed by the four AIDS work groups and presented to the Cabinet after a public comment period.

Chapter III, "Human Needs in the AIDS Epidemic" serves as the context for the AIDS Policy Principles and the Recommendations for State Action, which are presented below in the following order:

A. AIDS Prevention: Education and Intervention

B. Delivery and Financing of Health Care and Social Services

C. AIDS Counseling and Testing, Surveillance, Confidentiality, Discrimination, and Infection Control

A. AIDS PREVENTION: EDUCATION AND INTERVENTION

EDUCATION

Policy Principles

1. AIDS education is the primary weapon to prevent the spread of the Human Immunodeficiency Virus (HIV). There is currently no effective vaccine or cure for AIDS.

2. AIDS education to prevent the spread of HIV infection has several key components. One is providing accurate information that allays fears, corrects misconceptions, dispels myths and promotes a change in behaviors and attitudes about AIDS, HIV infection and those who are infected. Another is educating individuals so that they are motivated to change current behaviors and to build skills that will maintain alternative behaviors, reducing their risk of HIV infection. A third is offering individuals who engage in high risk behaviors and their sexual or needle sharing partners appropriate counseling regarding AIDS and HIV infection.

3. While the State of Connecticut must continue to provide leadership, education to prevent HIV infection is a shared responsibility. Everyone, including state, federal and local governments, professional associations, schools, community and religious groups, private sector business and institutions, must develop effective programs to prevent HIV infection. Collaboration, communication and coordination of these efforts is essential.

4. Funding for education on AIDS and HIV infection must be a priority and a responsibility shared by both the public and private sectors. Resources should be focused on those most at risk for HIV infection.

5. Everyone needs information on AIDS and HIV infection. Informing those whose behaviors (e.g. sharing needles or drug paraphernalia, engaging in risky sexual practices) pose the highest risk of HIV infection should be a priority. Behaviors that place people at risk of HIV infection, not any category or group of people, spread the AIDS virus.

6. AIDS information must be of high-quality, comprehensive, factual, understandable and direct. Its message must be repeated and reinforced until it is received. AIDS information should be age and group appropriate, culturally sensitive and linguistically appropriate. Educational efforts should be evaluated to ensure their effectiveness in getting prevention messages across.

7. Target audiences for AIDS education are individuals whose behaviors place them at high risk for HIV infection (e.g. sharing needles or drug paraphernalia, engaging in high risk sexual practices), student populations (pre-K to 12, post secondary, public and private), minorities

particularly in urban areas, women of childbearing age, health care and social services professionals, decisionmakers (e.g. legislators, government officials), employers and employees and the general public. Education should be appropriate to the skills and needs of each audience and take into account English proficiency and various literacy levels.

8. AIDS education and the training of health care providers and other social services professionals (e.g. teachers, police, emergency medical technicians, correctional officers), who may regularly come in contact with blood and bodily fluids in their work, is critical. It will allay their own fears of AIDS, enable them to provide sensitive and appropriate quality care and reduce their own minimal risk of becoming HIV infected on the job. Awareness about AIDS, as well as training on confidentiality and discrimination concerns regarding people with HIV infection, should be integrated into all aspects of the human services delivery system, including public, private, local and volunteer providers.

9. The State of Connecticut has a responsibility to educate its employees about HIV infection and to protect the rights of those employees who are HIV infected. Such efforts should be a model for employers in the private sector.

10. The State of Connecticut also has a responsiblity to educate individuals who are under its care, custody or jurisdiction. The AIDS message should be targeted to meet the needs and skills of each group.

EDUCATION

Recommendations for State Action

1. The State of Connecticut will continue to coordinate the state's AIDS education and prevention efforts through the Department of Health Services. The Department will communicate and collaborate with other governmental entities and private sector organizations that are involved in AIDS education efforts.

   In 1985, the Governor designated the Department of Health Services (DHS) as the lead agency for AIDS in Connecticut. In this capacity, DHS has developed, coordinated, and supported AIDS education efforts within state government and throughout the state. DHS provides consultation and expertise to other state agencies, such as the Department of Education, the Department of Correction and the Connecticut Alcohol and Drug Abuse Commission, as they develop and implement AIDS education programs. DHS also assists in the development of staff training and education in state agencies. Through the state AIDS public education program, DHS provides funding and technical assistance to nearly two dozen local agencies who provide AIDS education to their communities.

2. The State of Connecticut, through its state agencies, will continue to support AIDS education as a state priority in the fight against HIV infection. However, the state recognizes that resources will be needed in other areas, such as AIDS intervention and delivery of health care and social services to persons who are HIV infected.

3. The State of Connecticut will provide through its state agencies, particularly the Department of Health Services and the Department of Education, AIDS information that is comprehensive, factual, consistent, understandable, direct, age and group appropriate, culturally sensitive and linguistically appropriate. This information should particularly be focused on adults and youths engaging in high risk behaviors.

4. Each state agency, in consultation with the Department of Health Services, will provide AIDS information on preventing HIV transmission, to its employees and clients, including residents of state operated 24-hour facilities. Other components of AIDS education, as described in the AIDS Education Policy Principles, will be provided to agency employees and clients as appropriate.

   The Department of Health Services is working with private and public employers on AIDS training and has hired the American Red Cross to implement a state employee AIDS education plan using a "train the trainer" model to reach state employees.

5. Each state agency, in consultation with the Department of Health Services, will educate and train its employees who may come in contact with blood or bodily fluids in their work to observe the universal precautions required by the U.S. Occupational and Safety and Health Administration (OSHA) and recommended by the U.S. Centers for Disease Control (CDC) that treat every client and patient as though he or she might be infected with the AIDS virus.

   Current state agency efforts to provide AIDS-related training and education to their employees include: administrative guidelines for providing care to children and youth with AIDS developed by a task force on AIDS convened by the Department of Children and Youth Services that has been distributed throughout the Department; an Administrative Directive is being developed by the Department of Correction to provide AIDS training and education to correctional officers and other staff; a Comprehensive Staff Development Plan issued by the Department of Human Resources for training staff in serving clients with HIV infection; a Commissioner's Policy Statement issued by the Commissioner of the Department of Mental Health mandating infection control training for all 4,100 employees; and Medical Advisory Guidelines for the prevention of HIV transmission developed by the Department of Mental Retardation and distributed to all Department employees. The Connecticut Alcohol and Drug Abuse Commission provides on-going AIDS training to the staff of substance abuse and other related programs and, together with the Department of Health Services, has issued AIDS information and guidelines for substance abuse treatment programs.

INTERVENTION TO PREVENT THE SPREAD OF HIV INFECTION

Policy Principles

1. Interventions that prevent the spread of HIV infection are warranted.

2. Interventions to prevent the spread of HIV infection should include outreach programs to educate those at risk of HIV infection to take precautions in intravenous drug use and sexual activity.

3. Interventions to prevent the spread of HIV infection among intravenous drug users should include the expansion of substance abuse treatment programs and street outreach programs that educate intravenous drug users about AIDS and the transmission of HIV. These street outreach programs should also distribute bleach and condoms.

4. Intervention programs developed to prevent the spread of HIV infection should include evaluation components in order to monitor their effectiveness. Research and data collection is necessary to develop intervention programs that will most effectively stop the spread of HIV infection.

INTERVENTION TO PREVENT THE SPREAD OF HIV INFECTION

Recommendations for State Action

1. The State of Connecticut, through the Connecticut Alcohol and Drug Abuse Commission, will continue to support the expansion of substance abuse treatment programs to help curb the AIDS epidemic in the drug using community. Development of drug-free residential and outpatient treatment programs as well as methadone treatment programs should be emphasized so that more intravenous drug users have access to drug treatment programs.

2. The State of Connecticut, through the Connecticut Alcohol and Drug Abuse Commission, will continue to support street outreach programs for substance abusers, particularly for those who traditionally have not been reached by these efforts and those who have been disproportionately affected by AIDS. State funding will neither require nor prohibit the distribution of bleach or condoms. To be effective, outreach efforts should be culturally sensitive and linguistically appropriate.

Street outreach programs, currently funded through the Connecticut Alcohol and Drug Abuse Commission, provide information about HIV infection, drug treatment, and healthy practices, and some distribute bleach and condoms.

3. State operated or funded substance abuse prevention and treatment programs should provide clients with information on preventing HIV transmission. Appropriate substance abuse prevention and treatment program staff should receive AIDS-related training on HIV testing, pre- and post-test counseling, and other relevant topics such as loss and grief, and nutrition.

4. The decision to distribute bleach and/or condoms to persons residing in state operated or funded 24-hour facilities will be made by each individual state agency, in consultation with the Department of Health Services. Each agency should act as necessary in the best interest of their clients, their employees, and the public.

5. The Department of Health Services and the Connecticut Alcohol and Drug Abuse Commission will review data on needle exchange programs operating in other states as it becomes available, and make recommendations to the Governor's Human Services Cabinet on the operation and effectiveness of such programs and whether such programs should be implemented in Connecticut.

B. DELIVERY AND FINANCING OF HEALTH CARE AND SOCIAL SERVICES

SERVICE DELIVERY

Policy Principles

1. The State of Connecticut should encourage and monitor the development of systems of care needed by persons with HIV infection.

2. The State of Connecticut should not create a publicly administered system of care for persons with HIV infection and, in most cases, should not be a direct provider of care. The state does need to encourage and support community initiatives through its role as regulator, rate setter, payor and funder of direct services. As part of this process, the state should work closely with service providers in addressing the needs of HIV infected persons in Connecticut.

3. A separate system of health care should not be created to meet the needs of persons with HIV infection. Efforts to serve persons with HIV infection should be integrated into the entire health care delivery system.

4. Health care and related social services for persons with HIV infection should be driven by and be responsive to their needs.

5. Access to health care and social services should not be denied to individuals, based solely on their HIV infection status or perceptions about their HIV status.

6. Persons with HIV infection have health care and social service needs that parallel those of persons suffering from other chronic illnesses. In order to address these needs, a full array of institutional and community-based services should be available and accessible. The following services are needed in any system of care:

    General acute care hospitals
    Skilled nursing facilities
    Intermediate care facilities
    Hospice facilities
    Residential community care programs
    Acute psychiatric care
    Outpatient services
    Home health care
    Community day care
    Foster family care
    Outpatient psychiatric care
    Alternative housing
    Case management
    Support services
    Substance abuse treatment

7. Case management services should be available to persons with HIV infection at the community or regional level.

8. Coordination and collaboration among existing health care and social service providers at the community or regional level are required in order to deliver cost-effective quality care to those who are HIV infected in a timely fashion and in the least restrictive setting.

9. Health care and social services for persons with HIV infection should be provided in a manner which preserves or enhances their family and community relationships and minimizes unnecessary institutional care.

10. Community groups, churches, social clubs and professional associations should continue to take active voluntary roles in the provision of support services to people who are HIV infected.

11. Given the epidemiology of AIDS in Connecticut, health care and social services should be sensitive to the special needs of people whose behaviors place them at risk of HIV infection, particularly in populations which have a relatively high number of reported AIDS cases. Services to persons with HIV infection should be culturally sensitive and linguistically appropriate.

12. Initiatives, programs and services developed to respond to the needs of persons with HIV infection should include evaluation components in order to monitor their effectiveness.

13. Support should be provided for the research and data collection needed to develop policy and plan programs for the provision of services to persons with HIV infection.

SERVICE DELIVERY

Recommendations for State Action

1. The State of Connecticut, through its appropriate state agencies, shall convene an Interagency Task Force on AIDS Service Delivery and Financing Issues which will work to coordinate the state's role in meeting the program and service delivery needs of adults and children with HIV infection. State agencies which should participate on this task force include, but may not be limited to, the Department of Children and Youth Services, the Department on Correction, the Department of Health Services, the Department of Housing, the Department of Human Resources, the Department of Income Maintenance, the Department on Insurance, the Connecticut Alcohol and Drug Abuse Commission, the Commission on Hospitals and Health Care, and the Commission on Long Term Care.

   In addressing the state's role regarding the delivery and financing of services to persons who are HIV infected, the following should be considered:

a. Assessments of the health care and social service needs of persons with HIV infection made on statewide, regional and local levels.

b. Cost analyses of the current and projected costs of providing care to those who are HIV infected.

> The Department of Health Services and the Department of Income Maintenance have been involved in a study of the economic aspects of the care of AIDS patients in Connecticut. A contract for the study was awarded by the Department of Health Services to the Yale University School of Medicine to identify treatment patterns among Medicaid patients with AIDS and to recommend models for the organization of medical care delivery and financing. In addition, the Commission on Hospitals and Health Care is working with the Connecticut Hospital Association to develop hospital-based cost data on treatment for persons with AIDS.

c. Evaluations of the effectiveness of state funded initiatives, programs and services developed to respond to the AIDS epidemic.

2. The Interagency Task Force on AIDS Service Delivery and Financing Issues should be informed by input from public and private groups and agencies serving persons who are HIV infected. Groups and agencies that may have an interest include community-based AIDS organizations, community health centers, home care agencies, nursing homes, hospitals, and the Permanent Task Force on AIDS, advisory to the Department of Health Services.

3. The State of Connecticut will encourage increased access to, and reliance upon, appropriate home and community-based services for persons who are HIV infected, particularly for those persons who have traditionally experienced difficulty gaining access to health services due to low income, sexual preference, drug use or cultural and ethnic background.

4. The Department of Human Resources will continue to serve eligible clients who are HIV infected by offering case management services and support for home management and home care services.

> In 1988, the known caseload of persons with AIDS within the 13 district offices of the Department of Human Resources has risen to 48, a 40 percent increase over last year. Services provided by the Department include prevention, crisis intervention, case management, and home care services.

5. The State of Connecticut, through the Department of Health Services, will provide support to community-based AIDS organizations to enable them to continue their work providing essential support and coordination services to those who are HIV infected in their communities and to work in collaboration with other related community agencies and programs toward this end. They will also be encouraged to serve a range of persons who are involved in activities that put them at risk of contracting or spreading the AIDS virus, including those at risk in the community who are also Black and Hispanic, women, children, gay and bisexual men, and IV drug users.

6. The State of Connecticut, through the Deparment of Children and Youth Services, will continue its efforts to place HIV positive children unable to remain with their birth families in foster or adoptive families. The Deparment of Children and Youth Services will continue to offer support services to those foster families caring for HIV infected children, such as case management, counseling and support groups, and respite care.

   As of January, 1988, all 44 children who were diagnosed as HIV positive and unable to remain with their birth families were being cared for by foster or adoptive families. Of these 44 children, two have been adopted, eight have been returned to their birth families, three have died and the remaining 31 are currently in family foster care.

HOUSING

Policy Principles

1. The goal of the State of Connecticut's housing policy for persons with HIV infection is that decent and affordable housing be available on a non-discriminatory basis. Achievement of this goal will reduce reliance on long-term hospitalization and the use of emergency shelters by persons with HIV infection.

2. Because the needs of people with HIV-related illnesses vary, and each individual requires a different level of support, the State of Connecticut should encourage the development of a continuum of housing alternatives for adults and children with HIV-related illnesses. Housing options should include housing suitable for families and couples, in order to encourage them to stay together as long as possible. The following housing alternatives should be available:

   Housing in the private market
   Subsidized apartments
   Subsidized apartments with supportive services
   Subsidized housing in multi-family dwellings with supportive services
   Group residences without on-site staff supervision

Group residences with on-site staff supervision
Intravenous drug user residences

3. Housing should be available for persons with HIV-related illnesses in the least restrictive setting possible and with supportive services available as necessary. Services and supports to persons with HIV-related illnesses who are not homeless should be available to allow them to remain in their present homes. This approach should be considered before placement of persons in alternative housing.

4. Developing and financing housing options for people with HIV-related illnesses is both a public and private responsibility. This responsibility must be distributed fairly and appropriately between federal, state, and local government and private funding sources.

5. As provided in Connecticut General Statutes Section 46a-64, persons with or perceived to have HIV infection have full and equal access to housing and places of public accommodation as defined in Connecticut General Statutes Section 46a-63.

HOUSING

Recommendations for State Action

1. The efforts of the State of Connecticut with regard to housing for persons with HIV infection should focus on the need for housing for homeless persons with HIV-related illnesses. The Department of Human Resources will continue to support housing for homeless persons with HIV-related illnesses. Current programs to assist homeless persons with HIV-related illnesses should be reviewed regularly to determine the adequacy of services delivered and the projected future costs of these programs.

   The Department of Human Resources is providing funding for residences for persons with HIV-related illnesses who are homeless. In the two residences currently in the planning stage, each will house six to eight individuals and will employ a social worker who will assist in arranging for health, social, financial, legal, or other services required by the residents. Direct supportive services and counseling will also be available to residents and their families. It is expected that these facilities will be in operation during the current fiscal year. In addition, other forms of housing for persons with HIV-related illnesses that are privately financed, but are eligible for state support, are beginning to operate in at least one other city through the utilization of scattered site housing.

2. In order to assist in the establishment of supported housing for persons

with HIV-related illnesses in the community, the Department of Human Resources should:

a. Educate local officials, community leaders, and neighborhood groups about AIDS and the transmission of HIV to allay fears about persons with HIV infection, in collaboration with the Department of Health Services;

b. Advise and assist developers with the siting of housing in the community for persons with HIV-related illnesses; and

c. Explore the need for and feasibility of legislation to facilitate the development of supported housing for persons with AIDS in communities throughout the state.

3. The State of Connecticut, through the Department of Housing, will encourage Local Housing Authorities to adopt policies which prohibit discrimination in state or federally subsidized public housing against persons with, or perceived to have HIV infection.

FINANCING OF HEALTH CARE AND SOCIAL SERVICES

Policy Principles

A system for financing the cost of health care and social services for people with HIV infection should:

1. Distribute overall responsibility for the cost of HIV-related health care and social services fairly and appropriately between various government and private payors.
2. Provide Connecticut residents with HIV-related illnesses with access to needed health care and social services.
3. Provide reasonable, fair and timely reimbursement to individuals and institutions providing HIV-related health care and social services.
4. Direct the locus of HIV-related health care and social services to the most appropriate, least costly setting.

FINANCING OF HEALTH CARE AND SOCIAL SERVICES

Recommendations for State Action

1. Current public financing mechanisms will be examined by appropriate state agencies, such as the Department of Income Maintenance and the Commission on Hospitals and Health Care, on a periodic basis to determine the extent

to which these mechanisms adequately address the costs of care for persons with HIV-related illnesses.

2. As the current major financer of medical care for persons with HIV-related illnesses, the Department of Income Maintenance should continue to explore ways to encourage the use of home and community-based services and reduce reliance upon inpatient hospital care.

   The Department of Income Maintenance has explored the feasibility of implementing a Medicaid Home and Community Based Services Waiver for persons with HIV-related illnesses. An AIDS Home and Community-Based Services Waiver would allow the Connecticut Medicaid Program to provide reimbursement for case management services and enhanced home and community-based services to persons with HIV-related illnesses. It would also encourage the provision of the least restrictive, most appropriate and more cost effective care. However, the Department has not been able to show that a waiver would be cost effective, a requirement of the federal Health Care Financing Administration (HCFA), the entity that provides final approval and a 50 percent federal financing match for the waiver. Although the waiver cannot be shown to be cost effective at this time, the Department will continue to explore this option.

   The Department of Income Maintenance will continue to explore the option of adding targeted case management services for persons with HIV-related illnesses as a service covered under the State Medicaid Plan. The State Medicaid Program has the option of paying for case management services and may choose to target these services to selected groups of people, based on their diagnosis or condition (e.g. persons with HIV-related illnesses).

3. The Department of Income Maintenance should conduct a cost/benefit analysis of the option of subsidizing continued private health care insurance coverage for persons with HIV-related illnesses who become unemployed, as allowed by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

   The Consolidated Omnibus Reconciliation Act (COBRA) of 1985 mandates that employers of 20 or more persons must continue to offer former employees the opportunity to purchase medical insurance coverage for 18 months after cessation of employment. Some individuals who are HIV infected may want to continue their insurance, but they may not be able to afford it once they are unemployed. In order to assist these individuals who are HIV infected maintain their health care insurance for 18 months after cessation of employment, the Department of Income Maintenance should consider subsidizing such private health care insurance premiums. Because these individuals may soon qualify for Medicaid, it may be more cost effective for the

Department of Income Maintenance to subsidize the premium than pay the cost of care directly through Medicaid.

4. The State of Connecticut, through the Department of Income Maintenance, will continue to purchase AZT (Zidovudine) for low-income persons with HIV-related illnesses.

   It is the policy of the Connecticut Medicaid Program to provide Medicaid eligible individuals with coverage for all FDA approved drugs, including drugs approved for treatment of HIV infected individuals. Currently, the only AIDS-related drug approved by the FDA is AZT. In addition to those who are Medicaid eligible, the Department of Income Maintenance also purchases AZT for individuals diagnosed with HIV-related illnesses who are not Medicaid eligible and have incomes at or below 200 percent of the federal poverty level.

5. The Commission on Hospitals and Health Care should continue to evaluate whether hospital rates recognize the cost of providing care to persons with HIV-related illnesses.

   In October, 1988, the Commission on Hospitals and Health Care established new hospital reimbursement rates under the All Payor Prospective Payment System that reflect the higher costs to hospitals of providing for universal blood and body fluid precautions and that recognize the costs to certain hospitals that serve large numbers of persons with HIV-related illnesses.

6. The Department of Insurance should explore the feasibility of developing an affordable health care insurance product for medically uninsured persons with HIV-related illnesses through the state health care insurance risk pool.

   The Connecticut Health Care Act of 1975 (Public Acts 75-616 and 76-399) established the Comprehensive Health Care Plan run by the Health Care Reinsurance Association. This Comprehensive Health Care Plan was designed for Connecticut residents as a means of providing comprehensive coverage to individuals who do not have access to group insurance plans, or who lose their group coverage.

   The Comprehensive Health Care Plan requires a one-year waiting period before it will provide reimbursement for medical conditions existing at the time of application or for those treated within six months of application. As a result, most persons with HIV-related illnesses are precluded from obtaining coverage for care related to this illness during this waiting period. As it stands, the Comprehensive Health Care Plan is not a viable alternative for persons with HIV-related illnesses. Approximately 50 percent of persons with AIDS die within one year of their initial diagnosis and have high health care expenses. In addition, persons with AIDS who are either poor before the onset of the disease or become impoverished because of it, cannot pay the cost of the plan premiums which, while controlled, are high.

7. The Department of Insurance will continue to monitor private health insurance companies for compliance with state, federal and industry guidelines regarding policies and practices relating to persons who are HIV infected or are perceived to be at risk of HIV infection.

8. The Governor should advocate, through the Connecticut Congressional Delegation, for modification by Congress of Medicare eligiblity requirements for persons with HIV-related illnesses to allow them to start receiving benefits within several months of application instead of the current 24 month waiting period required for persons with disabilities.

   Persons diagnosed with AIDS are currently eligible for Medicare benefits and may start receiving coverage after they have satisfied the 24 month waiting period required for persons under age 65 with disabilities. This two year waiting period for Medicare eligibility is unrealistic for persons with AIDS considering that 70 percent die within two years of being diagnosed. Currently, Medicare does make an exception for persons under 65 who are suffering end stage renal disease by allowing them to receive benefits after a three month waiting period. Congress should extend a similar exception to persons with HIV-related illnesses.

9. The Governor should advocate, through the Connecticut Congressional Delegation, for continuation of federal funding for the purchase of AZT (Zidovudine) and other drug therapies of benefit to persons with HIV infection as they are approved by the Federal Drug Administration (FDA).

   The federal commitment to fund the purchase of AZT for low-income individuals who lack Medicaid or private insurance has been extended only through March, 1989.

C. AIDS COUNSELING AND TESTING, SURVEILLANCE, CONFIDENTIALITY, DISCRIMINATION, AND INFECTION CONTROL

COUNSELING AND TESTING

Policy Principles

1. HIV antibody counseling and testing should be anonymous or confidential and offered on a voluntary basis. HIV antibody testing should be based on informed consent.

2. HIV antibody testing should be performed prior to use of sperm, organ, tissue and blood or blood product donations.

3. Mandatory testing or screening of the general population or any sub-group to determine an individual's HIV status is not warranted. Mandatory testing of an individual solely to assess HIV status is not warranted, except in limited circumstances and in accordance with established protocols. In such a situation, the decision to test should be made on a case-by-case basis and only after consultation with appropriate medical and administrative personnel.

4. HIV antibody testing should not be a prerequisite to the provision of services by state agencies or agencies receiving state funds. However, a HIV positive result may be required for specific HIV-related services (e.g. AZT treatment, HIV support groups).

5. As stated in "AIDS Guidelines for State Personnel" (see Appendix C), the state of Connecticut should not test present or prospective employees for the presence of the AIDS virus (HIV) for the purpose of assessing employability.

6. HIV antibody counseling and testing should be routinely offered and encouraged by health care providers to people with high risk behaviors or others who request to be tested.

7. HIV antibody testing should be accompanied by pre- and post-test counseling that is scientifically accurate, culturally sensitive and linguistically appropriate.

8. HIV antibody testing should be performed in Department of Health Services certified laboratories using up-to-date testing technologies and protocols.

9. HIV antibody counseling and testing policies may need to be reevaluated periodically to respond to new significant scientific findings.

COUNSELING AND TESTING

Recommendations for State Action

1. The State of Connecticut, through the Department of Health Services, will continue to support the provision of voluntary anonymous and/or confidential counseling and HIV antibody testing at various sites throughout the state. Other state agencies should make their clients aware of the HIV antibody counseling and testing resources available in the state.

2. State agencies will establish protocols so that when HIV antibody testing is done by state agency personnel, it will be accompanied by pre- and post-test counseling. State agencies should take steps so that such counseling is scientifically accurate, culturally sensitive and linguistically appropriate.

3. State agencies, in consultation with the Department of Health Services, will establish protocols for obtaining informed consent where required prior to voluntary HIV antibody testing of individuals done by agency personnel. Informed consent must be given either in writing or orally and documented. Informed consent to testing requires an informed decision on the part of the individual to be tested that is based on at least the following information:

    a. an objective explanation of the test, including its purpose, potential uses, limitations and the meaning of its results; and

    b. an objective explanation of the testing and disclosure procedures to be followed. This includes information about the voluntary nature of the test and the confidentiality of test information (including the name of the test subject as well as the test results), and that the test subject may withdraw consent to the testing process and may remain anonymous in the testing process and in any subsequent disclosure of testing information.

    Informed consent to testing will not be obtained with coercion, which may include the threat of loss of rights or physical harm.

4. The State of Connecticut will not support the mandatory testing or screening of the general population or any sub-group solely to determine HIV status. Examples of groups that will not be tested in this manner include, but are not limited to, incarcerated populations, prostitutes, persons admitted to hospitals or other health care facilities, and those applying for marriage licenses. However, seroprevalence surveys by the Department of Health Services relying on blind testing (when the test result cannot be linked to the test subject) to determine the nature and

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prevalence of HIV infection in specific groups are appropriate.

5. The State of Connecticut will not support HIV antibody testing of an individual without informed consent (that is, if informed consent is either requested and denied or cannot be given or withheld) except in the following situations:

    a. In the rare instances in which a health care provider needs to test a person in order to provide necessary urgent medical care and the person cannot give or withhold consent.

    b. In facilities operated by the Department of Correction if the facility physician determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, only if no reasonable alternative exists that will achieve the same goal.

    c. In facilities operated by the Department of Correction if the facility physician and chief administrator of the facility determine that the behavior of the inmate poses a specific risk of transmitting the virus through blood and body fluid exposure to another person in the facility and no reasonable alternative exists that will achieve the same goal.

    d. In cases where a health care provider or other person in the course of their occupational duties has had a significant exposure of blood or bodily fluids and such exposure poses a significant risk for the worker of contracting HIV. An exposure evaluation group will determine that the worker has had a significant exposure and the person who is the source of the exposure, or his or her legal guardian, will not consent to the HIV antibody test.

6. The decision to test an individual without informed consent under testing recommendation #5 must be made on a case-by-case basis. In making such a decision, consideration of any of the following guidelines is encouraged:

    a. testing an individual will actually achieve the goal;

    b. there are no reasonable alternatives that will achieve the same goal and be less intrusive of the individual;

    c. negative consequences do not exceed the expected benefits of testing; and

    d. when available, a civil rights/patient advocate should be consulted.

7. State agencies, in consultation with the Department of Health Services, will establish protocols that conform with testing recommendations #5 and #6.

8. As stated in "AIDS Guidelines for State Personnel", state agencies will have policies and procedures in place to assure that present or prospective employees are not tested for the presence of the AIDS virus (HIV) for the purpose of assessing employability.

9. In order to assure that laboratory HIV antibody testing services are of high quality, the State of Connecticut, through the Department of Health Services, will continue to evaluate and certify, on a regular basis, laboratories offering HIV testing.

10. The State of Connecticut, through the appropriate state agencies, will periodically revise and update HIV antibody counseling and testing policies and protocols in order to reflect significant new scientific findings.

SURVEILLANCE

Policy Principles

1. The Department of Health Services should have primary responsibility for collecting, analyzing and disseminating information concerning the nature and prevalence of AIDS and HIV infection.

2. Epidemiological studies, including seroprevalence surveys with blind testing (when the test result cannot be linked with the test subject), should be conducted to determine the nature and prevalence of HIV infection in Connecticut.

3. Appropriate safeguards to prevent the disclosure of AIDS-related information reported to and collected by public health officials should be maintained.

SURVEILLANCE

Recommendations for State Action

1. The Department of Health Services will continue its leadership role in the surveillance and reporting of AIDS in Connecticut and continue to collect, analyze and disseminate information concerning the nature and prevalence of AIDS and HIV infection in the state.

2. The Department of Health Services will continue to perform epidemiologic studies, including seroprevalence surveys with blind testing (when the test result cannot be linked with the test subject), to determine the nature and prevalence of HIV infection in Connecticut.

AIDS surveillance is carried out through reporting of AIDS cases by health care providers and through seroprevalence studies conducted by the Department of Health Services. Populations on whom surveys are underway or being considered include people with tuberculosis, clients in sexually transmitted disease clinics, clients of women's health services, prisoners in correctional facilities and newborns. Most of these surveys will be "blind", that is, the identities of the subjects cannot be linked to their test results.

CONFIDENTIALITY

Policy Principles

1. HIV counseling and testing information, as well as HIV-related medical information, records and diagnoses, should be kept confidential. Disclosure without the authorization of an individual should only be allowed so that appropriate medical care can be dispensed or as necessary for compelling public health purposes. In addition, any information disclosed must be used in a legally and ethically defensible manner.

2. HIV-related information released about an individual to one person or provider should not be disclosed to any other persons or providers unless permission is specifically granted by the individual, except in limited circumstances.

3. Strict procedures should be developed and implemented to ensure confidentiality. Training for persons authorized to give and receive such information should be developed to preserve confidentiality.

4. There should be appropriate penalties for unauthorized disclosure of the medical records and information or HIV antibody test results of persons with HIV infection.

5. Partner referral programs to inform individuals who may be unaware that they are at risk of HIV infection should protect the identities of the HIV infected individuals and their partners.

CONFIDENTIALITY

Recommendations for State Action

1. Disclosure by state agencies of HIV counseling and testing information and HIV-related medical information, records and diagnoses, will be made

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only with the authorization of the individual, except in circumstances as noted below in confidentiality recommendations #2, #3, and #4. Authorization will be obtained either in writing or orally and documented.

2. The following individuals may have HIV counseling and testing information and HIV-related medical information, records and diagnoses disclosed to them without the individual's authorization (that is, if authorization is either requested and denied or cannot be given or withheld):

   a. The individual her/himself.

   b. Representatives legally authorized to consent to medical procedures.

   c. The individual's primary health care providers and the individual's attending health care personnel in order to give necessary medical care.

   d. Officials of local health departments or the State of Connecticut Department of Health Services Disease Prevention/Control Programs, for the purpose of reporting information as required by the Department of Health Services in regulation or statute.

   e. A health care provider responsible for an organ, blood or semen donation center that has received or will receive an organ, blood or semen from the individual.

   f. The medical examiner for determining cause of death or for epidemiologic purposes.

   g. An individual designated by court order to receive the information.

   h. In cases where a health care provider or other person in the course of their occupational duties has had a significant exposure of blood or bodily fluids and such exposure poses a significant risk for the worker of contracting HIV. An exposure evaluation group will determine that the worker has had a significant exposure and the person who is the source of the exposure, or his or her legal guardian, will not consent to the disclosure of HIV-related information.

   i. Employees of hospitals for mental illness operated by the Department of Mental Health, if the infection control committee of the hospital determines that the behavior of the patient poses a significant risk of transmitting the virus to another patient of the hospital.

      o Disclosure will only be allowed if it is likely to prevent or reduce the risk of transmission and no reasonable alternatives exist that will achieve the same goal and also preserve the confidentiality of the information.

- Such "reasonable alternatives" include counseling the patient concerning behaviors that pose a risk of transmission and other efforts to prevent or address the behaviors that pose a significant risk of transmission without disclosing the patient's HIV status or other confidential HIV-related information.

- Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information.

j. Employees of facilities operated by the Department of Correction to provide services related to HIV infection or if the facility physician and chief administrator of the facility determine that the behavior of an inmate poses a specific risk of transmitting the virus to another person in the facility.

3. In addition to the individuals described in confidentiality recommendation #2 above, other individuals may have such medical information, records and diagnoses disclosed to them without prior authorization of the individual (that is, if such authorization is either requested and denied or cannot be given or withheld) only as necessary for compelling public health purposes, such as preventing further transmission of the disease and if the following standards are met:

   a. the goal of the disclosure is consistent with ethical and legal principles;

   b. disclosure of the information is likely to achieve the goal;

   c. there are no reasonable alternatives that will achieve the same goal and also preserve the confidentiality of the information; and

   d. negative consequences do not exceed the expected benefits of the disclosure.

4. The decision by state agencies to disclose information under confidentiality recommendation #3 must be made on a case-by-case basis and only after consultation with appropriate medical and administrative personnel. When a state agency provides a civil rights/patient advocate, they should also be consulted if possible.

5. State agencies should ensure that adequate safeguards are developed so that HIV counseling and testing information and HIV-related medical information, records and diagnoses disclosed about an individual to one person or provider will not be disclosed to any other persons or providers unless specific permission is granted by the individual or

authority to disclose is provided under confidentiality recommendations #2, #3, and #4 above.

6. Each state agency will establish a protocol, in consultation with the Department of Health Services, to assure strict adherence to confidentiality recommendations #1 through #5.

7. In addition to establishing protocols in order to protect the confidentiality of HIV-related information, state agencies will provide adequate training to inform persons authorized to give and receive such confidential information of their responsibilities.

8. All state agencies must observe safeguards to prevent the inappropriate disclosure of HIV-related information that is reported to or collected by that agency.

9. Appropriate penalties including progressive disciplinary action for unauthorized disclosure of HIV counseling and testing information, records and diagnoses, will be developed by state agencies and used when required. Appropriate statutory civil or criminal redress should also be created.

10. State agencies will assist state-funded programs to develop and maintain adequate safeguards for confidentiality of HIV counseling and testing information, records and diagnoses.

11. The confidentiality and privacy of individuals and their sexual or needle-sharing partners will continue to be preserved in partner referral programs of the Department of Health Services.

12. State agencies will not release HIV-related information about individuals to persons conducting research without a specific written release from the test subject unless the information is released without identifiers or in aggregate form. The U.S. Centers for Disease Control may receive data in accordance with established protocols.

DISCRIMINATION

Policy Principles

1. Discrimination against persons with or perceived to have AIDS, ARC or HIV infection is illegal under the physical disability discrimination

provisions of Connecticut General Statutes Section 46a-51(15) and Section 504 of the federal Rehabilitation Act of 1973 (29 USC Section 794).

2. Persons with or perceived to have AIDS, ARC or HIV infection should have full and equal access to housing and all places of public accommodation without restriction or limitation. Any restriction or limitation should be regarded as illegal under Connecticut General Statutes Section 46a-63 and 64.

3. Equal access to and the same quality of health care that is available to others should be provided by health care providers to persons with or who are perceived to have HIV infection.

4. As stated in "AIDS Guidelines for State Personnel" (see Appendix C), the State of Connecticut shall place no restrictions on a person's employment solely on the basis of a diagnosis of AIDS, ARC or positive HIV antibody test, if that individual's health status enables him or her to perform the duties required by his or her employment. Furthermore, neither the perception of nor presence of HIV infection should be grounds for denying or terminating employment. The State may modify the duties of an employee based on medical recommendations or consistent with managerial prerogatives.

5. Local school systems should adopt policies consistent with the State Board of Education's administrative guidelines (see Appendix D) which state that a child who is HIV infected or perceived to be HIV infected should, in general, be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges and services provided by law and the local policy of each school district.

6. Persons who are HIV infected and under the care, custody or jurisdiction of the state of Connecticut should not be denied access to programs, services or privileges that would otherwise be offered soley because of their HIV status.

7. There should be provisions for expedited case processing and procedures for maintaining confidentiality for complainants in physical disability (AIDS) discrimination cases that are brought before the Commission on Human Rights and Opportunities.

8. Education and training are essential to reduce prejudice and discrimination against persons with or perceived to have AIDS or HIV infection.

DISCRIMINATION

Recommendations for State Action

1. The Commission on Human Rights and Opportunities (CHRO) should continue to process AIDS-related cases expeditiously. The CHRO should consider procedures for maintaining the confidentiality of the identity of complainants in AIDS-related cases, particularly in the public hearing process.

2. State agencies will have personnel policies and procedures in place consistent with "AIDS Guidelines for State Personnel" (see Appendix C).

3. State agencies will have policies and procedures in place so that persons who are HIV infected and residing in state operated or funded 24-hour facilities will not be denied access solely because of their HIV status to programs, services or privileges that would otherwise be offered.

4. The State of Connecticut will not segregate residents of state operated 24-hour facilities on the basis of HIV status alone.

5. The State of Connecticut, through its state agencies, will promote education and training programs that are designed to reduce prejudice and discrimination against persons with or perceived to have HIV infection.

INFECTION CONTROL

Policy Principles

1. Since it is impossible to know with absolute certainty which people have been exposed to the AIDS virus (HIV), all professionals who may come into contact with blood or body fluids in their work should observe the universal blood and body fluid health precautions recommended by the U.S. Centers for Disease Control (Appendix E), treating every client and patient as though he or she might be infected.

INFECTION CONTROL

Recommendations for State Action

1. State agencies, in consultation with the Department of Health Services, will establish protocols to assure that all state employees who may come in contact with blood or bodily fluid in their work will observe the universal blood and body fluid health precautions recommended by the U.S. Centers for Disease Control, treating every client and patient as though he or she might be HIV infected.

V. CONNECTICUT STATE GOVERNMENT RESPONSE TO AIDS

Below are summaries of AIDS-related activities through January 1, 1989 of the following state agencies:

A. Department of Health Services

B. Department of Children and Youth Services

C. Department of Correction

D. Department of Education

E. Department of Human Resources

F. Department of Income Maintenance

G. Department of Mental Health

H. Department of Mental Retardation

I. Connecticut Alcohol and Drug Abuse Commission

J. Commission on Long Term Care

K. Other State Agencies:

    Department on Aging

    Department of Housing

A. Department of Health Services

The Department of Health Services (DHS) is responsible for public health prevention programs, provision of certain health services, and regulation of health care providers. The AIDS Section is located in the Department's Bureau of Health Promotion which is responsible for reducing the occurrence of diseases caused by infectious and environmental agents and providing related services to maintain health and promote well being.

DHS has been addressing AIDS issues since 1982. In 1985, Governor William O'Neill named the Department lead agency on AIDS. The AIDS Section, which has grown from a $40,000 program to a $7 million program since 1985, is supported by both federal and state funds.

CURRENT AIDS RELATED EFFORTS

AIDS surveillance is carried out through reporting of AIDS cases by health care providers and through seroprevalence studies conducted by the Department. Other populations being surveyed being considered for surveys include people with tuberculosis, clients in sexually transmitted disease clinics, clients of women's health services, prisoners in correctional facilities and newborns. Most of these surveys will be "blind", that is, the identities of the subjects cannot be linked to their test results.

Case surveillance and seroprevalence studies are largely funded with federal grant support. Seroprevalence surveys in New Haven have been funded federally as part of a program of serosurveys in 30 selected sentinel cities across the United States.

With the strong support of the Department's AIDS Section, the state funded AIDS public education program is largely carried out by nearly two dozen local agencies. The Department recently hired Mintz and Hoke, an Avon, Connecticut advertising and public relations firm, to conduct a major statewide mass media/public information campaign. They have developed television and radio commercials with prevention messages that are currently being aired as public service announcements. They will be aired as paid advertisements with funds which are now being raised in the private sector. Mintz and Hoke has also developed posters and other materials and conducted a wide variety of media and public relations activities. They will continue to create new materials to reach individuals whose behaviors put them at risk.

Fifteen HIV counseling and testing sites now operate in eleven cities in the state, with new sites soon to be established. Anonymous or confidential HIV counseling and optional testing is available at these 15 sites: twelve sites are in local health departments, two are in hospitals, and one is in a nonprofit health agency. Between March, 1986, and Deceber, 1988, 10,334 people were tested in these sites. Approximately 7.2 percent have been found positive for HIV infection, as compared to an estimated seroprevalence of HIV infection in the general population of 0.5 percent. Demand for anonymous testing and counseling continues to be high. More outreach work needs to be done in order to increase the number of minorities, intravenous drug users and their partners who come to be tested at these clinics.

An initiative has been developed to make HIV counseling available to minorities, intravenous drug users and their sexual partners in New Haven, a high incidence city, by establishing a counseling and testing site at Yale New Haven Hospital.

In several Connecticut cities, HIV counseling and testing capabilities have been established with federal funding in facilities where people already receive health services such as family planning clinics and sexually transmitted disease clinics.

The Department has contracted with minority community-based organizations in Hartford, New Haven, Bridgeport and other cities. These organizations will use a peer education model to educate youth and drug users in order to prevent the spread of HIV among Blacks and Hispanics who comprise more than 50 percent of Connecticut AIDS cases. The Department has also set up a systematic program of consultation with minority community representatives by establishing Black and Hispanic Leadership Councils.

Whenever possible, the Department uses data concerning the knowledge, attitude and behavior of selected populations to target program interventions. A knowledge, attitude, and behavior survey of gay men has been conducted. Surveys of minority gay men, health care professionals, prisoners and other populations are planned or underway.

The Department works closely with the Connecticut Alcohol and Drug Abuse Commission (CADAC) on programs to offer counseling and HIV antibody testing to intravenous drug users, their sexual partners and significant others. Testing sites for drug users now exist in the state's methadone treatment programs, and nine sites are instituting outreach programs in the drug using community.

The Department has begun a voluntary partner referral program intended to inform people who may not otherwise be aware that they are at risk for HIV infection. HIV counselors will encourage individuals who are HIV antibody positive to inform their partners that they may have also been infected through sex or needlesharing. If they are not willing or able to inform their partners themselves, people who are infected may request that DHS program staff inform these partners of the potential risk. The identity of the infected person will not be disclosed to the partner at the time of referral and the confidentiality of the partners will be maintained. If appropriate, partners will be referred for counseling and testing.

All employers should be training their employees regarding AIDS prevention. The Department has worked with private and public employers on AIDS training. The Department has also hired the American Red Cross to implement a state employee AIDS education plan. They will use a "train the trainer" model to reach as many state employees as possible.

The Department contracted with Yale University Department of Epidemiology and Public Health, working under the auspices of the Connecticut Academy of Science and Engineering, to conduct a study of the future state resources which will be needed for health care for people with AIDS. This legislatively mandated study will in large part be based on data supplied by the merging of DHS data on reported cases of AIDS with Department of Income Maintenance data on AIDS costs reimbursed by Medicaid. The study's objectives are: to monitor patterns of health care services for persons with AIDS; identify service delivery gaps and other barriers to patients' ability to obtain needed services; estimate the costs of health services for people with AIDS; project for the public and private sectors future (1991) service needs and the economic impact of the treatment of AIDS in Connecticut and develop a system for monitoring services used by AIDS patients. The Academy issued an interim report in July, 1988 which gives preliminary analysis of the available cost data.

Connecticut's business and philanthropic communities have joined the Department in a public/private fundraising campaign to raise funds both for the state's media campaign and for prevention and support services that will be conducted by community agencies.

POSSIBLE FUTURE PROGRAMMING

The Department's goal is to have, within several years, one-on-one HIV counseling and testing available on a widespread basis in all regions of the state. Development of the counseling capability is especially important in facilities in which people are already receiving health care (e.g. urban health centers, family planning clinics, etc.). An ongoing system of training for health care professionals in the public and private sectors is also necessary, including training in counseling skills.

CONCERNS SHARED WITH OTHER DEPARTMENTS

As lead agency on AIDS, the Department has worked closely with all the state agencies addressing AIDS problems. The concerns of the Department include the range of concerns from those other agencies, as well as the concern of providing continued leadership in addressing the AIDS epidemic in the state.

CURRENT RESOURCES/FUNDING

The Department is funded by a combination of state and federal funds totaling over $7 million with approximately 45 percent of the funds from the state.

FUTURE RESOURCE NEEDS

Additional funding would enable the Department to expand existing AIDS education and prevention efforts, such as extending the minority peer education program to additional cities. The Department would also like to extend HIV counseling and testing capablity to existing health facilities such as urban community health centers.

The Department is committed to helping facilitate changes in the health care system to address the AIDS epidemic. Funding will be needed to encourage expansion of services to people with HIV infection.

B. Department of Children And Youth Services

The Department of Children and Youth Services (DCYS) serves Connecticut children under the age of eighteen and their families. This includes investigating reports of abuse, neglect and abandonment, assuring appropriate care for children whose families are incapable of caring for them, licensing foster family homes, adoptive homes, and child-caring and placing facilities, funding a range of community services, and operating three psychiatric hospitals. The Department operates a facility for children who are under the age of sixteen and who are adjudicated delinquents. The Department also provides aftercare and other services for adjudicated delinquents. As of January 1, 1989, the Department's average daily caseload was 12,371.

The Department's first principle is that children have a fundamental right to grow up as members of a family. As of January 1, 1989, of the 44 children in the state who are HIV positive and unable to remain with their birth parents, two have been adopted, eight have been returned to their birth families, three have died and the remaining 31 are currently in family foster care. The lives of these children are valued, and the Department's commitment to provide them with quality, family-based care is clear.

CURRENT AIDS-RELATED EFFORTS

A Department Task Force on AIDS was established in 1985 and developed "Administrative Guidelines for Providing Care to Children and Youth With AIDS." These guidelines and other educational materials have been distributed throughout the Department.

In October, 1987, a support group for foster parents with children who are HIV antibody positive began meeting in New Haven. This group has split into two and each group meets monthly with a mental health or therapeutic specialist. As a result of the interest developed through these support groups, the Department holds gatherings about four times a year which bring together foster families with children who are HIV antibody positive along with some of the children's birth parents and siblings. The Department provides support for these gatherings by funding the activities and providing transportation for those families in need.

The Aetna Foundation has given the Department about $54,000 to recruit foster families for children who are HIV infected and to provide support services. In addition, the Foundation produced a twenty-minute film to be used in recruiting foster families and educating communities about children with AIDS. The Foundation is also producing a booklet to be used to train foster families in the care of children with AIDS.

POSSIBLE FUTURE PROGRAMMING

Foster families will need ongoing training in the home care of HIV infected children, as well as supportive counseling and respite care. The Department will be providing AIDS awareness training to all staff and prospective adoptive and foster parents.

CONCERNS SHARED WITH OTHER AGENCIES

The Department's major concerns, which are shared with other agencies, include effective public education, testing and confidentiality, discrimination, and staff training in both the public and private sectors.

CURRENT RESOURCES/FUNDING

A number of local agencies and acute care hospitals are providing medical care and community support. Through the Department's board and care account, $1,090 is paid monthly to foster parents for care of a child who is HIV antibody positive. In addition, the account provides funds for respite care and disposable diapers. Medical expenses are funded by Title XIX (Medicaid), which is administered by the Department of Income Maintenance.

FUTURE RESOURCE NEEDS

As the epidemic grows, the number of children for whom the Department is responsible who are HIV infected will increase. All will require quality community services and family care. The Department believes funding will be required to sustain the requisite efforts of education, recruitment, support services, respite care and reimbursement of families who care for these infants and young children.

C. Department of Correction

Connecticut's average daily prison population exceeds 7,600. Each year, 40,000 men and women are admitted into the system. Since crime and drug abuse are so strongly linked, the corrections population is at high risk for HIV infection. The impact of AIDS on the correctional population over the next several years is expected to be considerable.

Currently, there are 450 inmates in the correctional system who have tested positive for the HIV antibody. Of these cases, 161 are in community release status. Since voluntary testing began in 1986, there have been 859 inmates who have tested positive. There have been a total of 60 AIDS cases since the first case in 1982, 32 of whom are now deceased.

A recent epidemiological study in the New York Department of Correctional Services found that 15 percent of 500 new admissions tested positive for the presence of the HIV antibody. While no direct extrapolation should be made currently to Connecticut, levels of HIV infection approaching this can be expected in the next several years.

Within the correctional setting, AIDS poses unique problems. Custody staff, especially custody staff in segregation and high security units, are exposed daily to inmate urine, feces and blood. Inmates have assaulted other inmates they suspect to be HIV infected. Providing security for inmates who are HIV infected may be as difficult as providing treatment to them.

CURRENT AIDS RELATED EFFORTS

The Department of Correction (DOC) is in the final stages of developing an Administrative Directive concerning AIDS. This directive will address AIDS education and training for staff and inmates, medical care for individuals who are HIV infected, and HIV counseling and testing.

Inmates who are HIV infected or suffering from AIDS Related Complex (ARC) are maintained in the general prison population unless their medical condition warrants separate housing. Male inmates diagnosed with AIDS are housed in the prison hospital at CCI-Somers. Females with AIDS are kept at the infirmary at CCI-Niantic. These inmates have many of the same programs as general population inmates but at different times and places. The Department prefers that persons with AIDS who are approaching death be placed in a community hospital.

The drug therapy AZT (Zidovudine) is being made available to all inmates diagnosed with AIDS. In addition, therapy is continued for all inmates entering the system who are already taking AZT. Because they may experience significant side effects from AZT, many inmates request that the drug be discontinued after a course of treatment. There is increasing support for providing AZT to persons who are HIV positive who have not yet been diagnosed as having AIDS. The DOC continues to monitor the use of AZT for persons who are in community programs such as supervised home release, parole, or community residential placement (halfway house) and will remain open to recommendations on the use of AZT from the U.S. Centers for Disease Control, the U.S. Food and Drug Administration and the State Department of Health Services.

The Department is involved in a joint effort with the Hartford Institute of Criminal and Social Justice to develop and distribute "discharge packets" to inmates leaving prison and returning to the community. The packets include AIDS educational materials, AIDS-related community resource information as well as condoms.

The Department is also conducting an inmate survey concerning their knowledge, attitudes and behaviors toward persons with HIV infection. When complete, this survey will provide Department policymakers with additional understanding concerning necessary inmate education programs.

POSSIBLE FUTURE PROGRAMMING

The Department is working with the Department of Health Services (DHS) to develop an AIDS awareness campaign and increase DOC counseling capabilities for persons infected with HIV. Prejudice against inmates with HIV infection by other inmates makes confidential counseling in the corrections setting problematic.

CONCERNS SHARED WITH OTHER DEPARTMENTS

Information and training to reduce the fear of contact with, and the discrimination against, people with HIV infection is being provided with the assistance of DHS. The prison environment, however, mitigates against minimizing those fears. Instead of attempting to single out inmates who are HIV infected, the Department has urged staff and inmates to assume that all bodily fluids are infectious.

The ethical and policy dilemmas of HIV antibody testing and the confidentiality of test results are still being addressed by the Department. The policy principles developed by the Governor's Human Services Cabinet will provide a framework for resolution of these issues.

The Department currently employs, under federal funds, one AIDS educator and three counselors. Federal funds have been made available to hire an additional nine counselors, some of whom will staff each of the Addiction Services Project FIRE (Facilitating Integration and Reentry Experience) offices throughout the state. In addition, funds were approved to hire an AIDS coordinator. These additional positions will allow the Department to broaden current HIV counseling as well as risk reduction and health education services.

With the Department's projections for significant increases in total inmate population, AIDS-related services will become more and more crucial to preventing the spread of this deadly disease.

FUTURE RESOURCE NEEDS

Hospital care and AZT are the two major resource needs facing the Department. Department officials are considering contracting for hospital spaces and for long term medical beds in a community setting. Hospice beds will also be necessary. Increased staff for both HIV counseling and education functions will be needed. Expanded testing based upon the U.S. Centers for Disease Control guidelines will also require additional resources.

D. Department of Education

The State Department of Education through its administrative arm, the State Board of Education, oversees school programs, licenses teachers and, in conjunction with local school systems, is responsible for the quality of the education and equality of educational opportunity offered to some 450,000 Connecticut youngsters in the state's public schools.

Currently few Connecticut children of school age are known to have HIV infection. The steadily increasing numbers of babies infected with the AIDS virus before or at birth are a future concern for educators. Nationally, and in one instance in Connecticut, school-age hemophiliacs with AIDS have encountered resistance from the parents of classmates when they attempted to attend classes. However, the Connecticut child was able to attend school as long as his physical health permitted.

In addition to ensuring that school age children with HIV infection are afforded their rights to a suitable program of educational experiences, the Department of Education is actively engaged in AIDS prevention education. This education is needed not because students can become HIV infected in the school environment but because statistics on sexually transmitted diseases confirm that many Connecticut youth are sexually active and in need of AIDS prevention information. It has to be assumed that when people in their twenties develop AIDS, it is the result of high-risk sexual or drug abusing behavior in their teens. Indeed, the Surgeon General of the United States recommends that education about the prevention of AIDS begin in the primary grades, before young people engage in activities that place them at risk for HIV infection.

CURRENT AIDS-RELATED EFFORTS

The Department of Education, working with the Department of Health Services (DHS) and representatives of the education community statewide, has already created three important documents. The first is a set of guidelines for school attendance of children with HIV infection. Prevention of Disease Transmission in Schools: AIDS, published in May, 1985, has had a distribution of more than eight thousand copies. Recently, the State Board of Education formally adopted the policy recommended in these guidelines (see Appendix D). That policy states that HIV infection, in and of itself, is not a reason to exclude a student from the regular classroom setting and that all educational decisions in this regard should be made on a case by case basis. The State Board of Education has also adopted this policy for the state's Vocational Technical School System, which is directly under State Board jurisdiction.

The second document is a suggested secondary school curriculum for AIDS prevention entitled "A Special Topic Resources Packet: AIDS." Over five thousand copies have been distributed. The third document, "A Special Topic

Resources Packet: AIDS," targeted for preschool, primary and elementary levels, was distributed in January, 1989.

Since 1985, three consultants with the Department of Education have presented over 2500 hours of inservice programs on AIDS to school administrators, teaching and support staff, custodians and cafeteria workers, parents and community leaders. These programs include such topics as: AIDS #101-Facts Replace Fears, School AIDS Policy, Transition without Transmission, Risk Reduction of Handling Body Fluids in Schools, Developing AIDS Curriculum Materials, Teaching AIDS Prevention to Students and AIDS Education in a Comprehensive Health Curriculum.

POSSIBLE FUTURE PROGRAMMING

Activities funded by a grant from the U.S. Centers for Disease Control focus on high risk adolescent populations, in collaboration with urban school districts, the Department of Correction and the Department of Children and Youth Services. Data are being collected to determine how many adolescents are receiving classroom instruction on AIDS prevention, as well as the nature and effectiveness of that instruction. Increase in staff is needed to meet demands for technical assistance by local school districts to comply with a new statute for mandatory K-12 AIDS prevention education by school year 1989-90.

CONCERNS SHARED WITH OTHER DEPARTMENTS

Educational opportunity, confidentiality, school attendance policy, HIV transmission risk, duty to warn, AIDS prevention through education, the theoretical risk of HIV infection versus the real risk, and response to anxiety of school personnel are important to the Department of Education and are concerns shared with other Departments.

CURRENT RESOURCES/FUNDING

State funds are used except for one full-time AIDS education coordinator position, a half-time project manager and one clerical position funded by a $215,000 grant from the U.S. Centers for Disease Control.

FUTURE RESOURCE NEEDS

Partial support for the programming proposed will come from the federal government. Funds for printing and distribution of educational materials are of particular concern.

E. Department of Human Resources

The Department of Human Resources (DHR) provides individuals and families with an array of social services. These services include prevention, crisis intervention, case management, protective services to the elderly, and home care services. The Department is also the designated lead agency in the provision of services to the homeless, victims of domestic violence, child day care, energy assistance, child support enforcement and the coordination of services to the mentally and physically disabled.

DHR is currently involved in locating housing as well as identifying and accessing health care and other supportive community-based services for people with HIV infection.

CURRENT AIDS-RELATED EFFORTS

Over the past year the known caseload of persons with HIV infection within DHR's 13 district offices has risen to 48, which represents a 40 percent increase over the previous year. In providing direct services to individuals with HIV infection, DHR social workers assess all aspects of the individual's or family's functioning including health, environment, ability to perform activities of daily living, social support systems, financial management, and emotional and mental functioning. The assessment is used by the social worker to determine client needs. Following assessment, the social worker coordinates a plan of care which may include the provision of paid services such as homemaker, meals on wheels, day care, chore person, and a variety of other services. The social worker, as case manager, coordinates this plan and may also provide direct intervention, including counseling and taking action on behalf of the client in order to readjust the environment to improve the client's circumstances. The social worker acts as a liaison between the client and the institutions and systems which have an impact on the client and his or her family. Assessment and coordination of a plan (which may include both paid services and direct intervention) is followed by ongoing monitoring of the client's situation in order to revise the case plan as needed. The majority of the DHR cases of people with HIV infection previously had been identified in Hartford, Bridgeport, and New Haven; however DHR offices in Middletown, Waterbury, and Norwich have now reported major increases in their cases as well.

A two year pilot project has been established to provide primary health care, screenings, and follow-up to homeless individuals and families in eight shelters in Hartford. As part of this project, registered nurses educate and train shelter providers about communicable diseases including HIV infection.

DHR provides funding to six health clinics throughout the state. These clinics provide primary health care to low income residents and have identified and treated people with HIV infection as part of the eligible population they serve.

A protocol and health guidelines manual regarding HIV infection for use by homeless shelters was produced through the cooperative efforts of the Department of Human Resources and the Department of Health Services.

Residences, supported by DHR grant funds, are being planned in two locations for persons with AIDS who are homeless. Each residence houses six to eight individuals and will employ a social worker who will assist in arranging for health, social, financial, legal, or other services required by the residents. Direct supportive services and counseling will also be available to residents and their families. It is expected that these facilities will be in operation during the current fiscal year. In addition, other forms of housing for persons with AIDS that are privately developed, but are eligible for state funding, are beginning to operate in at least one other city through the utilization of scattered site housing.

DHR and several of its grantees have been actively involved with the Connecticut AIDS Consortium, a statewide collaborative effort that will enable up to $1 million in grants from private foundations to be made in the next two years. The Consortium has issued requests for proposal in order to provide grants to community-based non-profit organizations for case management services, preventive education and housing to limit the incidence and growth of AIDS in the state.

DHR district office staff are actively involved with AIDS task forces in Bridgeport and New Haven. The New Haven Task Force developed a support service directory for persons with HIV infection.

DHR is a member of the Connecticut AIDS Residence Coalition that was established in February, 1988 and provides staff time to support the Coalition.

DHR, as a result of its long history of working with community-based organizations, has devoted ongoing efforts to ensuring that Black and Hispanic low income communities are effectively being reached by AIDS prevention and education programs. In addition, DHR's statewide Hispanic service grantee, the Connecticut Association For United Spanish Action (CAUSA), is participating in the Connecticut AIDS Consortium. CAUSA also assists Hispanic community-based agencies in applying for AIDS prevention and education funds.

DHR also works with Community Action Agencies (CAAs), which form another service delivery system currently addressing the issue of AIDS. Health statistics document the rapid spread of the AIDS virus especially among residents of low-income and minority communities, areas which CAAs have traditionally served. CAAs represent a significant tool in the prevention of this epidemic since they can effectively reach populations with individuals whose behaviors put them at risk of becoming HIV infected. Through a network of neighborhood centers strategically located in the target communities, CAAs can deliver, coordinate and sponsor a wide variety of human service programming beneficial to the client or potential client with HIV infection.

To date, CAAs have employed a variety of methodologies directed to respond to the AIDS crisis:

- Enhancement of staff awareness of AIDS and AIDS-related issues. As examples, Community Action Agency of New Haven (CAANH) and Thames Valley Council for Community Action (TVCCA) held workshops educating staff on the risks, problems and misconceptions of AIDS; and Norwalk Economic Opportunity Now (NEON) held an in-service training program for managers and staff in providing services to clients with HIV infection.

- Expansion of AIDS public awareness and training by offering AIDS education workshops to the community-at-large. For example, New Opportunities for Waterbury (N.O.W.) conducted a one-day community meeting regarding AIDS and also received a grant from the Connecticut Alcohol and Drug Abuse Commission (CADAC) to promote community awareness. Community Action Agency of Greater Middletown (CAGM), in conjunction with local health care providers, has presented AIDS Awareness workshops at their neighborhood centers. NEON held an education and employment workshop for employers of persons with HIV infection and a workshop for the summer youth program participants dealing with AIDS education and prevention. Other CAAs have held community education workshops in areas with minority populations designed to increase awareness of AIDS and to stress ways of preventing the spread of the disease.

- Initiation of activities to expand the CCAs' comprehensive information and referral system to include AIDS information, and to strengthen the supportive services for persons with HIV infection. As examples, Windham Area Community Action Program (WACAP), as part of their community wide client oriented coordinated services system, refers individuals with AIDS to the local health center, one of the programs WACAP sponsors. CAANH, at their intake site, has brochures which identify local health care providers who deal with AIDS. CAGM is seeking an HIV counselor to be stationed at one of CAGM's neighborhood offices. NEON provides office space for a worker in the minority outreach program, which disseminates AIDS information, distributes condoms, and provides information and referral service to drug abusers.

- Recognition that there is great potential for more coordination and collaboration between health care and human services providers regarding AIDS. For example, NEON has agreed with the Norwalk Health Department to be a full participant in any program dealing with AIDS. Many CAAs have proposed to intensify their programming efforts in the future to provide additional services to persons with HIV infection. N.O.W. is proposing to expand its programming by offering casework/case management services and furthering its community education projects by targeting groups with individuals whose behavior puts them at high risk of becoming HIV infected and designing preventive programs, especially for minority groups. Community Renewal Team of Greater Hartford (CRT) will soon be hiring a person to provide AIDS prevention and education training to participants in its Youth and Action Program. Other CAAs have utilized the staff from local health departments to participate in community AIDS awareness and education.

POSSIBLE FUTURE PROGRAMMING

DHR has completed, with the assistance of the Personnel Development Center of the Department of Administrative Services, a comprehensive staff development plan for DHR staff at all levels. This plan includes recognition of needs by DHR staff, particularly district office social workers, for training in serving clients with HIV infection. This is an area that will receive attention as the training and staff development recommendations are implemented.

Increased bonding funds to establish residences for persons with AIDS as well as appropriated operating funds for these facilities.

Increasing funding for home care and home management services to persons with HIV infection in the community through the essential services account and other funding sources, in conjunction with expanded case management through DHR district office social workers.

CONCERNS SHARED WITH OTHER DEPARTMENTS

Staff training as well as the educating and training of other community-based service providers is critical in order that they have a better understanding of AIDS and are less reluctant to work with people with HIV infection.

The need for development of AIDS policies and protocols for family day care homes and day care centers (e.g. the acceptance and maintenance of children with HIV infection in day care settings).

The Health Department, as the licensing agency for child care centers throughout the state, needs to be included as a source for referral and information. Data collection must be improved, so as to better track AIDS cases, case disposition and cost impacts.

Legal issues relative to client confidentiality.

Clear responsibilities for each state agency providing services or funding to people who are HIV infected must be outlined and developed into cooperative agreements. This would support a coordinated service delivery system to persons with HIV infection and their families.

CURRENT RESOURCES/FUNDING

Bonding funds in the amount of $1,000,000 and operating funds of

$100,000 are targeted for the AIDS community residence program in SFY 1989.

The Primary Health Care Project, which has expected funding of $150,000, provides on-site health care services.

Home care services are funded out of the Department's Essential Services Account. Approximately 48 cases of people with HIV infection now receive assistance for community-based services.

FUTURE RESOURCE NEEDS

Alternative funding to cover community-based services; development of a continuum of care, including post-acute and community-based services; family respite care; and bereavement counseling.

F. Department of Income Maintenance

The mission of the Department of Income Maintenance (DIM) is to provide support and services to people in need and to promote their fullest potential for self-sufficiency and independent living. Among its programs is the Medical Assistance (Medicaid) program, which reimburses medical professionals for the care they provide to Connecticut's needy citizens. The Department pays health care providers with state funds and then receives approximately fifty percent reimbursement from the federal government.

Quantifying the impact of AIDS on Connecticut's Medicaid program has proven difficult because AIDS manifests itself not as a specific disease, but as a series of illnesses all related to immune system failure. However, the growing prevalence of AIDS, particularly among the state's low-income population, and the high cost of AIDS-related care raise serious concerns for the Department.

CURRENT AIDS-RELATED EFFORTS

Medicaid is the single largest payor of AIDS-related care in Connecticut, funding almost half of all AIDS-related charges. Approximately 55 percent of persons with AIDS in the state qualify for the Medicaid program at some point in their illness. The analysis of SFY 1988 Medicaid program data indicates that the rate of increase in the number of AIDS cases receiving medical assistance has begun to slow. From SFY 1987 to SFY 1988, the number of AIDS cases receiving assistance increased from 68 to 123 (80 percent), down slightly from the 100 percent increase between SFY 1986 and SFY 1987. Total AIDS-related health care expenses increased 64 percent, from $1.4 million in SFY 1987 to $2.3 million in SFY 1988.

The distribution of Medicaid reimbursed health costs reflects changes in the management and treatment of AIDS in Connecticut. Inpatient costs accounted for 75 percent of total AIDS health care expenses in SFY 1988, down from 85 percent in SFY 1987. This is in part due to a decline in the average length of stay from 17.2 days to 16 days and in the annual number of discharges from 2.3/per person to 1.6/per person. At the same time, there has been a 50 percent increase in the utilization of outpatient services, most notably home health care and pharmacy services, including purchase of the drug AZT (Zidovudine).

The Connecticut AZT Program continues to purchase AZT for low income individuals who do not qualify for Medicaid. In SFY 1988, 79 individuals received assistance for an average of nine months. It is expected that the Connecticut AZT Program will serve 158 individuals in SFY 1989 and 236 in SFY 1990.

DIM developed an application for a Medicaid home and community based service waiver for persons with a diagnosis of ARC or AIDS. A discussion draft was circulated to all state agencies and the appropriate provider, voluntary and advocacy groups. However, a fiscal analysis of the AIDS Medicaid waiver found that community-based services would not be cost-effective due to current Medicaid reimbursement rates for inpatient care.

POSSIBLE FUTURE PROGRAMMING

The Department has concluded that the AIDS Medicaid waiver application will not meet the federal Health Care Administration (HCFA) cost effectiveness test and cannot be submitted at this time. In lieu of the waiver, the Department is investigating other options to provide community-based services for persons with AIDS, including a State Medicaid Plan amendment for targeted case management services.

CONCERNS SHARED WITH OTHER DEPARTMENTS

The Department is actively pursuing coordination with the Office of Policy and Management and other state, local and private agencies to identify the best possible allocation of limited state funds for expanded AIDS-related services.

CURRENT RESOURCES/FUNDING

Projections for the State Medicaid Program in SFY 1989 include an increase in the number of Medicaid AIDS cases to 215 at a cost of $4.1 million, rising to 358 individuals at a cost of $8 million in SFY 1990.

In August, 1987, the federal government provided Connecticut with $306,000 for a state AZT Program for low income, non-Medicaid eligible individuals. In SFY 1988-89, a state appropriation of $700,000 was made to further support the Connecticut AZT program. In September, 1988, the Connecticut AZT program received a supplemental federal appropriation of $153,000 that continues the federal committment through March, 1989.

FUTURE RESOURCE NEEDS

The Department will continue to pursue state funding for the operation of the Connecticut AZT Program. The Department is prepared to respond to future AID-related financing initiatives funded by the federal government.

G. Department of Mental Health

The Department of Mental Health (DMH) provides and supports a comprehensive array of mental health inpatient and community-based programs for the citizens of Connecticut who have reached their eighteenth year. The Department has a special responsibility for individuals who are at risk of hospitalization and to individuals who live with serious prolonged mental illness.

Overall, the population served by DMH or in DMH supported programs does not necessarily represent a high risk population. Currently, there are 22 known patients in DMH-operated facilities with HIV infection: one inpatient with AIDS and 21 inpatients who are HIV positive, and 11 outpatients with AIDS and 18 outpatients who are HIV positive.

Despite this low incidence, individual patients who engage in high risk behaviors for AIDS are a significant concern if they exibit aggressive behavior around other patients or staff that raises the potential of contact with body fluids. These considerations require re-examination and refinement of infection control techniques. DMH recognizes that it has a special responsibility to provide staff and patients with AIDS education and information. Broadly, the concerns of DMH are similar to those in the general health care sector.

CURRENT AIDS-RELATED EFFORTS

Training on AIDS issues was begun within the Department in 1985 by the Infection Control Coordinators/Nurses. A network was established within this group in order to achieve consistency of policies and procedures and educational goals. Until August, 1987, the training was concerned primarily with direct health care workers, although many other non-direct care workers were reached.

In August, 1987, a Commissioner's policy statement was promulgated mandating infection control training for all 4,100 DMH employees. This policy requires initial training for employees at the time of orientation, on an annual refresher basis, and whenever special training activities may be indicated.

POSSIBLE FUTURE PROGRAMMING

In August, 1987, the Commissioner appointed a Task Force on Infection Control, with an emphasis on AIDS, comprised of medical staff leadership throughout the Department, including infection control staff. One of the recommendations was that AIDS information and counseling be provided to all patients except where clinically contraindicated. There had been some educational activities provided on AIDS for patients, but a new emphasis in this area was required at this time. The Department of Health Services (DHS) has supported and assisted in this training. All Department of Mental Health facilities were surveyed to assess their interest in this course. Forty-six staff members within DMH have made a commitment to become trainers. These trainers play a key role in carrying out the mandate of the Commissioner's policy statement on infection control.

A final significant concern for DMH is ongoing attention to programs designed to meet the mental health needs of persons infected with HIV.

CONCERNS SHARED WITH OTHER DEPARTMENTS

The many issues of concern that DMH shares with other agencies include HIV antibody testing as opposed to screening, confidentiality, collaboration with community-based providers, whether disease prevention justifies the distribution of condoms to patients, and physical management of HIV infected patients who may potentially be aggressive or careless regarding their bodily fluids.

A continuum of community services in the form of readily accessible supports for patients with AIDS, whose inpatient treatment has been completed, also echoes the concerns of several other agencies for their clients.

CURRENT RESOURCES/FUNDING

Support for current initiatives comes from state funds. Existing program budgets in such areas as infection control and staff development have served to cover the expenses of DMH-sponsored training; however, as in other hospitals, the increased requirements for training and infection control have had costs. Interagency assistance from DHS in terms of staff training has been provided.

FUTURE RESOURCE NEEDS

DMH needs better data on the projected HIV positive population in its institutions that will be served in the future, in order to project future budgeting needs and plans. The Department has already adopted universal blood and body fluid precautions; as with other hospitals, this initiative in DMH will require vast numbers of disposable gloves, mouth pieces and/or ambu-bags for use in cardiopulmonary resusitation (CPR), which must be readily available in all wards and clinics for all certified personnel. Masks, protective eyewear, gowns or shields must also be available for use during certain procedures, and for use when patients or clients exhibit potentially hazardous behavior. In addition, DMH must assess the demands that care for AIDS-related dementia will place on their treatment programs in the future, so that they can be prepared to meet these demands.

H. Department of Mental Retardation

Although the Department of Mental Retardation (DMR) provides a variety of services to almost 9,000 clients, currently only five individuals are known to be HIV antibody positive.

Some clients require ongoing supervision since they are unable to comprehend the consequences of certain behaviors or exhibit diminished impulse control. Although persons with mental retardation are not at high risk for HIV infection, they may be drawn into high risk sexual behavior by more capable persons.

CURRENT AIDS-RELATED EFFORTS

In December, 1987, the Department distributed "Medical Advisory Guidelines for the Prevention of HIV Transmission" to all DMR employees. These guidelines address issues of education and prevention for both employees and clients.

Ongoing education about HIV transmission and protective supplies and equipment are provided to all DMR employees, especially the direct contact staff. The Department also collaborates with private service providers to assure that their personnel and governing boards are fully informed on AIDS.

POSSIBLE FUTURE PROGRAMMING

With an increase in the number of mothers who are infected with HIV, the Department expects an increase in the number of HIV antibody positive infants referred to DMR early intervention services. The Department has no firm basis for projecting the number of adult clients who may become infected with HIV over the next few years.

CONCERNS SHARED WITH OTHER DEPARTMENTS

The Department is also concerned about the need for education in the prevention of HIV transmission for clients, family, friends, and staff; legal issues with regard to placement, testing, and confidentiality; financial issues related to increased client supervision; and future patient care issues.

CURRENT RESOURCES/FUNDING

State funds are used to purchase infection control supplies and for staff and client training.

FUTURE RESOURCE NEEDS

It is difficult at this time to make meaningful predictions about future funding needs for DMR clients or for prevention activities. The Department will continue to pursue community integration of its clients and to encourage the use of community resources and health care facilities for its clients. The Department does not plan to establish separate facilities to care for groups of clients who may develop AIDS.

I. Connecticut Alcohol and Drug Abuse Commission

The Connecticut Alcohol and Drug Abuse Commission (CADAC) is charged with alcohol and drug abuse prevention, intervention and rehabilitation efforts in the State. The Commission fully or partially funds 96 community substance abuse treatment programs and administers four state-operated treatment programs.

Intravenous (IV) drug users represent a significant number of the state's population who are at risk for AIDS. As of December 31, 1988, 51 percent of the 1,021 AIDS cases diagnosed in the state were the direct or indirect result of IV drug use. This includes the number of cases of IV drug users with AIDS and the number of persons with AIDS who became infected because they were the sexual partner or child of an infected IV drug user. Fifty-five percent of new cases of AIDS reported in 1988 were associated with IV drug use. It should be noted that 66 percent of the AIDS cases among Hispanics and 63 percent of the cases among Blacks are IV drug users and that 78 percent of cases in women and 88 percent of cases in children are IV drug use related.

CURRENT AIDS-RELATED EFFORTS

CADAC does not have a specific AIDS prevention mandate. However, the epidemic is so closely linked to IV drug abuse that the Commission has become an active partner with the Department of Health Services (DHS) in AIDS prevention efforts.

CADAC provides on-going AIDS training to the staff of substance abuse and other related programs. CADAC, together with DHS, has issued AIDS information and guidelines for substance abuse treatment programs. It also administers HIV antibody counseling and testing sites located in seven substance abuse treatment programs and HIV risk reduction outreach worker programs located in nine cities.

POSSIBLE FUTURE PROGRAMMING

Addictive behavior is not often changed without specific treatment programs. However, the drug treatment programs have waiting lists. An increased system-wide capacity for treating IV drug users should be part of a plan to prevent HIV transmission. Recommended actions to help accomplish this will include additional AIDS educators and nursing staff in programs, and more residential and methadone slots, with special emphasis on meeting the needs of cocaine abusers and members of minority groups who abuse drugs.

CONCERNS SHARED WITH OTHER DEPARTMENTS

Insurance coverage, testing protocols, confidentiality issues and the availability of services for IV drug users with AIDS who require either hospitalization or home health care are concerns that CADAC shares with other agencies.

CURRENT RESOURCES/FUNDING

Sources of federal funding for current efforts are the Health and Human Services Alcohol and Drug and Mental Health Block Grant and the U.S. Centers of Disease Control. State funding also plays an important role in supporting the CADAC AIDS program.

FUTURE RESOURCE NEEDS

Funding will be needed to maintain our current treatment and prevention capacity as well as to maintain our AIDS prevention and training efforts.

J. Commission On Long Term Care

The Commission on Long Term Care is mandated to develop and implement a coordinated state policy on long term care. As set forth in the enabling statute, long term care means "health, social services or personal care provided on a recurring or extended basis to anyone of any age who is unable to cope with the tasks of daily living because of a physical or mental impairment."

The members of the Commission are the Commissioners of the state's major human service agencies which plan and implement policies and programs in this area. The member agencies are Health Services, Mental Health, Mental Retardation, Human Resources, Income Maintenance, Aging, Children and Youth Services and the Commission on Health and Hospital Care. In addition, several agencies have been added to the Commission as ad-hoc members as allowed in the enabling legislation. The ad-hoc members include the Office of Policy and Management, the Connecticut Alcohol and Drug Abuse Commission, and the Departments of Education and Housing.

The Commission is assisted in its task by a thirteen member Advisory Board on Long Term Care. Appointed by the Governor and the leadership of the General Assembly, the Advisory Board represents the perspectives of consumer advocacy groups, formal care providers, and the public in general.

CURRENT AIDS-RELATED EFFORTS

The Commission's Advisory Board has adopted a set of policy goals pertaining to the role of nursing homes in the AIDS crisis.

Through the Commission, the Commissioners are pursuing a model of care that enables service recipients, advocates, providers and governmental officials to share a set of common goals and sense of direction. This model of care should integrate services, be responsive to changing client needs, be comprehensive, and facilitate transferring and/or joint service provision when multiple governmental agencies are involved.

When special needs identified for specific populations or conditions emerge, the Commission advocates client driven community-based alternatives while considering the system's context, normalization, and fiscal impacts.

While the provision of direct services is not a task done by this agency, it does have responsibility for considering the many factors that ensure the efficient delivery of needed services. AIDS is a topic covered in "An Inventory and Update of Selected State Government Activities and Responsibilities in Long Term Care," which is a vehicle for the coordination of policy and planning efforts of its members. The Commission also maintains a formal mechanism for interagency dialogue and problem resolution on both policy and service delivery decisions. Thirteen agencies and the Office of the Attorney General participate through an interagency agreement.

The Commission has also recently produced an "Array and Continuum of Housing Arrangements: A Client Driven Model," which displays six levels of care correlating housing, treatment, supervision and independent living variables. The model points out the need for a comprehensive view of where people with AIDS may reside at varous points during the course of their illness and what services may be needed. The model also indicates the need for AIDS treatment and standards at a variety of levels of care.

POSSIBLE FUTURE PROGRAMMING

The Commission will maintain itself as a forum to further the above activities and respond to emerging issues. In concert with the Governor's Human Services Cabinet, the Commission will be advocating a strong public and private partnership and strengthening of the capacity of the state system of care to serve people with HIV infection.

Other issues requiring ongoing attention are funding levels; protocols for admissions, denials, discharges, and transferring; respite; training; data collection; and confidentiality. In keeping with its mandate, the Commission will continue to ensure that an interagency perspective is balanced with the concerns of each agency.

CONCERNS SHARED WITH OTHER DEPARTMENTS

All concerns of the Commission are shared with two or more agencies, including ongoing coordination.

CURRENT RESOURCES/FUNDING

Staff resource time will continue to be directed toward these efforts. No direct service funds are appropriated to the Commission.

FUTURE RESOURCE NEEDS

No additional resources are needed at this time.

K. Other State Agencies

Department on Aging

The Department on Aging (SDA) is reponsible for developing programs and providing services for Connecticut's seniors, by addressing the needs of the state's elderly population directly and through contracts with service providers statewide. The primary state-supported efforts are the Promotion of Independent Living Contract, the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE), and the Ombudsman Program.

Although the Department on Aging does not currently have a major role in the AIDS issue, they have served some persons with AIDS through ConnPACE, the prescription drug assistance program for eligible seniors and persons who are disabled. The Department has assisted persons obtain prescriptions for AZT in the past, although no one is currently obtaining AZT through this program.

The Department has also provided training on AIDS at their annual Aging Network Conference. The Aging Network is comprised of all SDA funded agencies and programs providing services to seniors.

Department of Housing

The Department of Housing (DOH), the lead agency for housing-related matters in the state, administers state housing programs for Connecticut citizens with low and moderate incomes, and coordinates federal housing and community development programs within the state. In addition, the Department works with the Office of Policy and Management, the Departments of Human Resources, Aging, Economic Development, and Income Maintenance, the Connecticut Housing Financing Authority, and the Connecticut Housing Authority.

The Department cooperates with the Department of Human Resources (DHR) in the financing of housing opportunities for people who are homeless, and has agreed to work cooperatively both with DHR and with local housing agencies to ensure that persons with AIDS receive a fair share of available housing. In addition, working through the Corporation for Independent Living, a private non-profit corporation, DOH has provided funds through its Housing Development Corporation program to assist in financing rehabilitation of existing housing to make it accessible.

APPENDICES

A. TABLES AND FIGURES

B. SUMMARY OF TESTIMONY AT THE PUBLIC FORUMS ON AIDS

C. STATE PERSONNEL GUIDELINES

D. STATE BOARD OF EDUCATION GUIDELINES

E. U.S. CENTERS FOR DISEASE CONTROL GUIDELINES

F. REPORT TO GENERAL ASSEMBLY BY P.A. 87-527 AIDS TASK FORCE

APPENDIX A

TABLES AND FIGURES

The following tables and figures on AIDS in Connecticut are referred to in Chapter II of this report.

NOTE: When reviewing tables or figures, two points should be kept in mind. The first is that crude incidence rates do not adjust for structural differences, such as age, between groups. Second, because of lag time between diagnosis and report of AIDS cases, data for 1988 should be considered provisional. It is expected that cases and rates for that year will increase as reports continue to be received.

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF AIDS CASES IN CONNECTICUT

REPORTED CASES BY SEX, AGE AT DIAGNOSIS AND RACE/ETHNICITY
JANUARY 1, 1980* -- DECEMBER 31, 1988

TOTAL NUMBER OF CASES = 1021

AGE	WHITE N	BLACK N	HISPANIC N	OTH/UNK N	TOTAL N	Col %
			MALE			
Less Than 13	2	13	4	0	19	(2)
13-19	0	0	0	0	0	(0)
20-29	81	52	35	1	169	(21)
30-39	168	128	70	3	369	(45)
40-49	84	57	24	0	165	(20)
50+	74	19	4	0	97	(12)
TOTAL	409	269	137	4	819	(100%)
			FEMALE			
Less Than 13	1	10	3	0	14	(7)
13-19	0	0	0	0	0	(0)
20-29	14	29	8	1	52	(26)
30-39	24	49	16	1	90	(45)
40-49	9	14	3	0	26	(13)
50+	13	7	0	0	20	(10)
TOTAL	61	109	30	2	202	(100%)

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*The first Connecticut case was diagnosed in 1980; however, the first case to be reported was reported in 1981.

TABLE 2:
AIDS CASES BY TRANSMISSION CATEGORY, SEX & RACE/ETHNICITY: CONNECTICUT AS OF DECEMBER 31, 1988

	RACE/ETHNICITY									
TRANSMISSION CATEGORY	WHITE		BLACK		HISPANIC		OTHER/UNKNOWN		TOTAL	
	#	%	#	%	#	%	#	%	#	%
Homosexual/ Bisexual Males	308	65.5	68	18.0	31	18.6	3	50.0	410	40.2
IV Drug Users	64	13.6	210	55.6	97	58.1	2	33.3	373	36.5
Males	31	6.6	142	52.8	81	59.0	1	25.0	255	31.1
Females	33	54.1	68	62.4	16	53.3	1	50.0	118	58.4
Homosexual/Bisexual IVDU Males	27	5.7	28	7.4	14	8.4	0	0	69	6.8
Hemophiliac Males	12	2.6	0	0	0	0	0	0	12	1.1
Heterosexual Cases*	20	4.3	41	10.8	14	8.4	1	16.7	76	7.4
Males	7	1.5	13	4.8	4	2.9	0	0	24	2.9
Females	13	21.3	28	25.7	10	33.3	1	50.0	52	25.7
Transfusion	23	4.9	2	0.5	0	0	0	0	25	2.4
Males	10	2.1	1	0.4	0	0	0	0	11	1.3
Females	13	21.3	1	0.9	0	0	0	0	14	6.9
Undetermined	13	2.8	6	1.6	4	2.3	0	0	23	2.3
Males	12	2.6	4	1.5	3	2.1	0	0	19	2.3
Females	1	1.6	2	1.8	1	3.3	0	0	4	2.0
Pediatric	3	0.6	23	6.1	7	4.2	0	0	33	3.2
Males	2	0.4	13	4.8	4	2.9	0	0	19	2.3
Females	1	1.6	10	9.2	3	10.0	0	0	14	6.9
TOTAL	470	46.0	378	37.0	167	16.3	6	0.5	1021	100.0
Males	409	49.9	269	32.8	137	16.7	4	0.5	819	100.0
Females	61	30.2	109	54.0	30	14.9	2	1.0	202	100.0

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*This category includes persons who have had heterosexual contact with a person who has AIDS, or is at risk for AIDS, as well as persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

TABLE 3:
CRUDE INCIDENCE RATES OF AIDS FOR THE STATE OF CONNECTICUT, COUNTIES AND SELECTED TOWNS BY YEAR OF DIAGNOSIS: DECEMBER 31, 1988

RATES PER 100,000 POPULATION

AREA	TOTAL CASES	1980	1981	1982	1983	1984	1985	1986	1987	1988**
STATE										
CONNECTICUT	1021	0.0+	0.2	0.4	0.8	2.4	3.9	6.8	8.6	8.2
COUNTIES										
New Haven	360	0	0.1	0.8	1.4	2.9	5.1	10.7	12.4	12.0
Fairfield	304	0.1	0.4	0.9	0.6	4.0	4.2	8.0	9.7	8.3
Hartford	248	0	0.1	0	0.7	1.6	4.6	6.0	8.1	8.2
New London	46	0	0	0	0	1.2	0.8	3.6	4.8	7.8
Litchfield	18	0	0	0	0.6	1.2	1.2	2.4	2.4	2.9
Middlesex	18	0	0	0	0.8	0	3.8	1.5	4.3	2.8
Windham	12	0	0	0	0	1.1	3.2	1.0	5.1	2.0
Tolland	8	0	0	0	0	0	0.8	0.8	2.4	1.6
Unknown	8	---	---	---	---	---	---	---	---	---
TOWNS										
New Haven	215	0	0.8	2.4	5.5	8.7	16.6	45.9	47.2	42.3
Hartford	155	0	0	0	1.5	3.7	21.4	21.5	34.3	32.9
Bridgeport	83	0	0.7	0	0.7	4.9	7.0	13.9	16.0	14.7

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*Population for 1980 is from the 1980 Census. For the other years, estimates of population are based on Connecticut Department of Health Services projections. **Especially for 1988, data are provisional because of lag in reporting. +This was rounded from 0.03.

TABLE: 4A

CONNECTICUT AIDS CASES BY YEAR OF REPORT AND ANNUAL PERCENT CHANGE: JANUARY 1, 1981 - DECEMBER 31, 1988

YEAR OF REPORT	NUMBER	PERCENT CHANGE
1981	2	---
1982	7	+250
1983	22	+214
1984	54	+145
1985	88	+63
1986	173	+97
1987	273	+58
1988	402	+47
TOTAL	1021	---

TABLE: 4B

CONNECTICUT AIDS CASES BY YEAR OF DIAGNOSIS AND ANNUAL PERCENT CHANGE: JANUARY 1, 1980 - DECEMBER 31, 1988

YEAR OF DIAGNOSIS	NUMBER	PERCENT CHANGE
1980	1	---
1981	5	+400
1982	13	+160
1983	24	+85
1984	76	+217
1985	126	+66
1986	220	+75
1987	282	+28
1988*	274	-3
TOTAL	1021	---

* Especially for 1988, data are provisional because of lag in reporting.

TABLE 5:

SEROPREVALENCE OF HIV ANTIBODY BY SELECTED CONNECTICUT POPULATIONS

POPULATION GROUP	NUMBER TESTED	NUMBER POSITIVE	% POSITIVE
Blood Donors* (3/85-12/88)	751,733	93	0.012
Military Recruits** (10/85-9/88)	16,091	25	0.16
Newborn Infants (9/88-10/88)	5,589	13	0.23
STD Clinic Sites & CARE Program (12/87-12/88)	127	6	4.7
Family Planning Clinics (10/88-12/88)	14	1	7.1
Alternative Test Sites (3/86-12/88)	10,334	744	7.2
Drug Treatment Centers (3/86-12/88)	1,402	182	13.0

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*Information is provided by the American Red Cross, Connecticut Branch.

**Information is provided by the U. S. Centers for Disease Control.

TABLE: 6

MILITARY RECRUITS: HIV ANTIBODY SEROPREVALENCE BY SEX, RACE/ETHNICITY AND AGE AT DIAGNOSIS CONNECTICUT AND U.S.A.

10/85-9/88

POPULATION	CONNECTICUT	U.S.A.
TOTAL		
Recruits Tested	16,091	1,799,771
# Positive	25	2,419
% Positive	0.16	0.13
SEX		
Males Tested	13,844	1,546,302
% Positive	0.17	0.15
Females Tested	2,247	253,469
% Positive	0.04	0.07
RACE/ETHNICITY		
Whites Tested	12,615	1,309,308
% Positive	0.05	0.07
Blacks Tested	2,519	344,390
% Positive	0.60	0.37
Hispanics Tested	588	85,189
% Positive	0.51	0.21
Others Tested*	369	60,881
% Positive	0.27	0.16
AGE		
17-19 % Positive	0.05	0.04
20-24 % Positive	0.11	0.19
25-29 % Positive	0.69	0.40
30-44 % Positive	0.50	0.35
45+ % Positive	0	0.11

*Others: Includes Asian and Native Americans or unknown race.

SOURCE: U. S. Centers for Disease Control

TABLE 7: SEROPREVALENCE OF HIV ANTIBODY AMONG CLIENTS OF 15 ALTERNATIVE COUNSELING AND TESTING SITES BY TRANSMISSION CATEGORY, SEX AND RACE/ETHNICITY

CONNECTICUT, JANUARY TO DECEMBER 1988

TRANSMISSION CATEGORY	RACE/ETHNICITY				
	WHITE % POSITIVE (# TESTED)	BLACK % POSITIVE (# TESTED)	HISPANIC % POSITIVE (# TESTED)	OTH/UNK % POSITIVE (# TESTED)	TOTAL % POSITIVE (# TESTED)
Homosexual/ Bisexual Males	10.1 (845)	10.0 (50)	40.4 (44)	16.7 (12)	11.6 (951)
IV Drug Users	10.6 (536*)	36.2 (105*)	37.3 (177*)	0 (2)	19.6 (820*)
Males	11.0 (346)	41.5 (82)	40.4 (151)	0 (1)	22.9 (580)
Females	9.8 (183)	18.2 (22)	20.8 (24)	0 (1)	11.7 (230)
Homosexual/ Bisexual Males & IVDUs	11.1 (36)	50.0 (6)	37.5 (8)	100.0 (1)	21.6 (51)
Hemophiliac Males	0 (1)	0 (0)	0 (0)	0 (0)	0 (1)
Heterosexual Contact	1.0 (2381*)	5.1 (392*)	7.7 (259*)	3.6 (56)	2.2 (3088*)
Males	0.7 (1164)	6.9 (188)	9.7 (103)	5.4 (37)	2.2 (1492)
Females	1.4 (1178)	3.5 (198)	6.0 (150)	0 (19)	2.1 (1545)
Transfusion	1.5 (65)	40.0 (5)	0 (4)	0 (1)	4.0 (75)
Males	0 (29)	0 (1)	0 (1)	0 (0)	0 (31)
Females	2.8 (36)	50.0 (4)	0 (3)	0 (1)	6.8 (44)
OTHER/UNKNOWN	2.9 (278*)	11.8 (17*)	12.5 (32)	9.5 (21*)	4.6 (348*)
Males	4.9 (102)	14.3 (7)	36.4 (11)	15.4 (13)	9.0 (133)
Females	1.8 (167)	12.5 (8)	0 (21)	0 (4)	2.0 (200)
TOTAL	4.4 (4153*)	12.1 (576*)	21.3 (526*)	7.5 (93*)	6.9 (5354*)
Males	5.6 (2523)	16.8 (334)	30.2 (318)	11.5 (64)	9.2 (3239)
Females	2.4 (1564)	6.0 (232)	7.1 (198)	0 (25)	3.3 (2019)

*Subcategory totals include clients whose sex is unknown.

TABLE 8: AIDS CASES IN CONNECTICUT
BY YEAR OF DIAGNOSIS AND
FOUR TRANSMISSION CATEGORIES*
JANUARY 1, 1980 - DECEMBER 31, 1988

YEAR OF DIAGNOSIS	HOMOSEXUAL/ BISEXUAL MALE		IV DRUG USER		HOMOSEXUAL MALE & IVDU		HETEROSEXUAL CASES**		ALL CASES	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
1980	1	(100)	0	---	0	---	0	---	1	(100)
1981	3	(60)	1	(20)	0	---	0	---	5	(100)
1982	7	(54)	1	(8)	0	---	2	(15)	13	(100)
1983	11	(46)	8	(33)	2	(8)	0	(0)	24	(100)
1984	32	(42)	18	(24)	10	(13)	6	(8)	76	(100)
1985	60	(48)	38	(30)	12	(10)	3	(2)	126	(100)
1986	86	(39)	84	(38)	11	(5)	18	(8)	220	(100)
1987	107	(38)	119	(42)	16	(6)	18	(6)	282	(100)
1988***	103	(38)	104	(38)	18	(7)	29	(11)	274	(100)
TOTAL	410	(40)	373	(37)	69	(7)	76	(7)	1021	(100)

*These four transmission categories are mutually exclusive. They do not include all transmission categories and, therefore, do not add to the column "ALL CASES."

** This category includes persons who have had heterosexual contact with a person who has AIDS, or is at risk for AIDS, as well as persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

***Especially for 1988 cases, data are provisional because of lag in reporting.

APPENDIX B

SUMMARY OF TESTIMONY AT THE PUBLIC FORUMS ON AIDS

September 14, 1988 - Hartford

September 19, 1988 - New Haven

GOVERNOR'S HUMAN SERVICES CABINET

Summaries of
Public Forum Testimony on AIDS
September 1988

I. PREVENTION: EDUCATION AND INTERVENTIONS

EDUCATION

General

- There needs to be a centralized body to coordinate statewide education efforts
- Need for regional planning to coordinate community based education
- Work with target communities to develop messages that community members can related to
- Community based organizations (CBOs) are a critical provider of AIDS education since they have knowledge and trust of their communities
- There is a need for increased intensive community based education which is well focused and sustained
- To ensure cultural sensitivity, community people and programs should be involved in the planning and provision of community education programs.
- CBO's and AIDS groups should be brought together in the RFP process to encourage cooperative community education program
- Education for minorities living in poverty and for IV drug users must be designed to build self-esteem and empower individuals
- There is a need for peer group education

IV drug users

- IV drug users and their partners are a critical population to target for education. The Cabinet should devote a whole section of their report to this population

Prison Inmates

- Multiple education opportunities are needed for all prison inmates
- Frequent use of educators from outside DOC are needed to increase credibility

Children

- Direct, truthful, comprehensive and continuous education in the schools that cover substance abuse, sexuality, and AIDS

Gay/bisexual men

- There is a need for education that is "explicit" and culturally sensitive to the gay community

Employers

- The state of Connecticut should encourage private businesses to provide AIDS education to all their employees

Professional training
- State funded training should be provided on an ongoing and periodic basis to all service providers
- Professional schools and training programs should be encouraged to incorporate AIDS education and counseling skills development into the undergraduate and graduate curriculums so that all new graduates in the health care fields are able to deliver effective AIDS education to their patients and the general public
- Public health, professional organizations, licensing and accreditation agencies must cooperate to provide continuing AIDS education for health care providers. All public and private providers of health care services should provide AIDS education to their health care workers
- Support education and training of all persons providing direct services, from outreach workers, to school teachers in order to help eliminate ignorance, prejudice and fear of AIDS and increase sensitivity to those with high risk behaviors.

INTERVENTIONS FOR PREVENTION

IV drug users
- Expansion of drug treatment programs
  - Drug treatment upon demand [criticized refusal of medical providers to put IV drug users on AZT until they begin treatment for drug abuse]
  - Fund more detox units
  - Critical need for expansion of long term residential treatment slots: short term outpatient treatment is only a bandaid
  - Increase reimbursement rates for drug treatment: state pays $1950 for a treatment slot that costs $3,000
  - Develop treatment that is more responsive to blacks and Hispanics
  - Develop drug treatment programs that are more sensitive to the needs of women [What do women do with their children while in drug treatment?]
  - Support methadone maintenance and counseling delivered at home for addicts who are debilitated
- Develop a comprehensive response to AIDS among IV drug abusers
  - Support and expand street outreach and education with bleach and condoms
  - Consider pilot needle exchange project
  - Consider decriminalizing the sale of needles and syringes: repeal state statute Section 21a-65
- Against needle exchange programs
- Against decriminalization decriminalizing the sale of needles and syringes: repeal state statute Section 21a-65
- Prevention efforts among IV drug users have a direct impact on their needle and sex partners, women and children

Condoms
- Increased education and availability of condoms
- No - Condom distribution in prisons

- Yes - Condom distribution in prisons
- Yes - Condom distribution in juvenile detention

Contact tracing
- Support contact tracing
- No contact tracing

II. TREATMENT AND SERVICE DELIVERY AND FINANCING

TREATMENT AND SERVICE DELIVERY GAPS

Treatment
- Greater emphasis is needed on treatment as the immediate priority

Coordination of services
- A comprehensive and coordinated service system is needed for people affected by the entire spectrum of HIV infection
- A system of care should reflect the specific needs and existing resources of each community

Case Management
- Case management systems organized by county
- Statewide and regional coordination

Home care
- Home care is generally available, but often inaccessible due to inadequate reimbursement and funding
- Reimbursement is needed for 24-hour home health aides
- The inability of some home health providers to care for those who are HIV infected is largely rooted in:
  - The growing shortage of nurses and home health aides
  - The lack of funding to pay for the higher cost of providing services

Alternative outpatient care facilities
- There is a need for the development and expansion of multidisciplinary outpatient treatment programs
- Care is needed from early HIV infection onward

Therapeutic drug treatment
- Encourage the development of experimental medications and work with private sector
- Continue state subsidy of AZT, including coverage for low and moderate income employed people
- Subsidize payment for Aerosolized Pentamadine for the prevention and treatment of Pneumocystis Carinii

Housing
- The Connecticut AIDS Residence Coalition applied for a $1.8 million grant from The Robert Wood Johnson Foundation

- o Housing and residence options are needed for those who are not drug free
- o Housing is not only needed for individuals, but for families
- o The state should curtail local zoning power when used to prohibit the citing of small residential AIDS facilities as it has done for those serving the mentally retarded or mentally ill
- o Development of housing needs to be supported by a partnership of state, local and private resources. The full range of housing needs should be planned and supported by state and local government

Pediatric AIDS care programs
- o These programs are only found at Yale and UCONN. Similar programs should be delivered in other high incidence communities such as Stamford, Norwalk, Bridgeport

Primary health services for IV drug abusers
- o More programs are needed like the Central Medical Unit for addicts in New Haven that received state funds this year

Dentists

Day Care
- o For adults and children

Respite

Mental Health Services
- o Acute and chronic psychiatric care
- o Mental health counseling for those who are HIV infected and their families and loved ones

Intermediate and skilled nursing care facilities
- o In order to encourage or enable these facilities to serve persons with AIDS, a special reimbursement level is needed [$105/day falls short of the cost of care which is estimated to be about $170/day]

Hospice care

Foster care for adults

Counseling and support
- o This should include financial, pastoral and legal counseling

Role of community-based organizations [CBOs]
- o CBOs receive only minimal funding. There is no clear state funding system that provides funds directly to CBOs
- o State funding should be made directly available to CBOs, they are the most effective in getting the AIDS message out to their communities and in providing direct services, counseling and case management

Development of delivery system
- o Identify gaps in present delivery system

- Estimate the needed volume of each level of care based on current and projected cases: CHA is in the process of developing estimates. The state and CHA should share data
- Develop a strategy to encourage the establishment of needed services
- Expedite the certificate of need process for the approval of new AIDS-specific programs and services

FINANCING

Public/private partnerships

- Encourage collaboration between private and public financing to pay for treatment and services
- Provide incentives for creative ways to spread risk through new pooling mechanisms, such as multiple employer trusts or state or regional pools, to help make coverage afforable
- Encourage formation of reinsurance programs specifically for AIDS
- Explore way of subsidizing premiums for the continuation coverage required by the 1986 Comprehensive Omnibus Reconciliation Act (COBRA) for individuals who are disabled with AIDS when they leave employment
- Expand mandatory minimum health care coverage to include home and community based services

Medicare

- With the help of the Congressional delegation, the state should initiate efforts to modify the 2-1/2 year waiting period for those disabled by AIDS to qualify for Medicare

Medicaid

- Medicaid reimbursement is too low to cover the cost of care for persons with AIDS [Nursing homes, home health agencies, physicians]
- Support the proposed Medicaid Home and Community Based Waiver but with reimbursement levels that reflect the cost of care

Uninsured

- There is inadequate financing support for the non-Medicaid uninsured

SPECIAL POPULATIONS IN NEED OF SERVICES

IV Drug users and their sex and needle sharing partners

- Highest risk population

Women

- All women of all ethnic and racial backgrounds, of all ages, not just reproductive age, are in need of information, education and services related to HIV infection
- There is a need for expanded counseling and testing programs especially designed for poor and minority women
- Multidisciplinary outpatient services are needed that are structured to meet the complex medical and psychosocial needs of HIV infected women, their children and families

Children

- Need for family support: mental health, babysitting and respite
- Need to address the needs of those children who are not HIV infected, but have family members who are infected

Gay/Bisexual men

- We should not abandon our efforts in supporting the needs of gay/bisexual men who still represent the majority of new cases of AIDS
- Black and Hispanic gay/bisexual men need to be addressed more fully

III. COUNSELING AND TESTING, CONFIDENTIALITY, DISCRIMINATION, INFECTION CONTROL

COUNSELING AND TESTING

Testing

- Set standards for informed consent
- Spell out exceptions to mandatory testing of individuals
- No mandatory HIV testing of:
  - accused rapists
  - persons in public institutions
  - convicted prostitutes
  - prison inmates

Counseling

- Counselors should receive standard training and should be periodically evaluated. DHS should require this for grant recipients

CONFIDENTIALITY

Disclosure

- HIV status should be disclosed to foster care providers
- Clarify when and under what circumstances the duty to disclose without consent outweighs duty to maintain confidentiality
- Discontinue "red dot" system in prisons
- Penalties should be specified for unauthorized disclosure

Duty to warn

- Partner notification is not necessary or cost effective
- There should be contact tracing
- Public health officials, rather than physicians, should have the responsibility to notify partners

DISCRIMINATION

Legislation

- Claims made to CHRO are not handled adequately and need priority status

- Those with AIDS-related complaints should be allowed to take them to another legal service if CHRO doesn't deal with complaint within 30 days or within 90 days
- Support a separate anti-discrimination law for discrimination on the basis of HIV status

Policy

- Non-discrimination of persons who are HIV infected should be a requirement of state funding
- Testing should not be a condition for receiving services. Universal precautions should be observed
- Section 504 of the federal Rehabilitation Act of 1973 prohibits discrimination against qualified handicapped persons in programs or activities receiving federal financial assistance. The regional Office of Civil Rights of the Department of Health and Human Services has interpreted this to include persons who have or are perceived to have AIDS or AIDS-related conditions

INFECTION CONTROL

Appendix E of the Cabinet's report should be updated with "Update: Universal Precautions for Prevention of Transmission of HIV, Hepatitis B, and other Bloodborne Pathogens in Healthcare"; MMWR; June 24, 1988; Vol. 37, No. 4

VI. GENERAL ISSUES

Coordination and implemenation

- Need for a lead agency to coordinate AIDS planning
- Greater inter-agency coodination is needed regarding delivery and financing of services and data collection
- Need administrative regulations to institutionalize the principles endorsed by the Human Services Cabinet
- Emphasize the need for public/private partnerships
- Any evaluation, research or data collection effort must respect and maintain the confidentiality of the information

Community-based organizations

- Acknowledge the response going on in communities, especially urban communities, for several years. State government is building on a foundation laid by numerous community-based organizations and volunteers

Philosophy

- "We must move from understanding AIDS as an inevitably fatal disease, where we wait for a person to die, to a chronic disease, where we are called upon to help people with AIDS live and love and be loved as full members of our society"
- Emphasize the need to provide services to not only HIV infected individuals, but their families and loved ones

SPEAKERS AT PUBLIC FORUMS
ON AIDS INTERIM REPORT
OF GOVERNOR'S HUMAN SERVICES CABINET

HARTFORD--SEPTEMBER 14, 1988,

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APPENDIX C

STATE PERSONNEL GUIDELINES

The following guidelines were prepared by the Department of Health Services to assist State supervisors, managers and personnel officers when addressing personnel issues and questions about AIDS and HIV infection. These guidelines also offer information and recommendations for those State employees involved in the direct health care of persons who have AIDS or HIV infection. They are based on current medical information and are consistent with the advice of the U. S. Centers for Disease Control (See Appendix E).

STATE OF CONNECTICUT

AIDS GUIDELINES FOR STATE PERSONNEL

REVISED

APRIL, 1989

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AIDS GUIDELINES FOR STATE PERSONNEL

INTRODUCTION

The following guidelines were prepared by the Department of Health Services (DHS) to assist State supervisors, managers and personnel officers when addressing personnel issues and questions about the Acquired Immunodeficiency Syndrome (AIDS). These guidelines also offer information and recommendations for those employees involved in the direct health care of persons who have AIDS or who may have been infected with Human Immunodeficiency Virus (HIV), the virus that causes AIDS and AIDS Related Complex (ARC). They are based on current medical information and are consistent with the advice of the U.S. Centers for Disease Control (Morbidity and Mortality Weekly Reports 1987; 36 (Suppl no. 25): 15-185 and 37: 377-87 as well as the Departments of Labor and Health and Human Services Joint Advisory Notice of October 30, 1987). The guidelines will be changed if significant new information becomes available which affects the content.

BACKGROUND INFORMATION ON AIDS (2)

AIDS is caused by a virus called Human Immunodeficiency Virus (HIV) which attacks and damages the immune system - the body's normal self-defense mechanism against infection. The diagnosis of AIDS is made when a person with HIV infection, as a result of damage to the immune system, develops infections or cancers that do not normally occur in healthy persons. These infections or cancers are known as "opportunistic diseases." In persons with AIDS, mortality is high; to date, approximately 80% have died within two years of the development of symptoms. However, persons with AIDS may feel well enough for periods of time to participate in everyday activities including employment. Physicians expect persons with AIDS to live longer in the future, with the availablity of new antiviral and immune boosting therapies.

Most individuals (60-70%) infected by the AIDS virus have no symptoms at this time. Approximately 20% of all those infected have developed symptoms commonly known as AIDS-related complex (ARC), including weakness, malaise, weight loss and generalized lymph gland enlargement. Symptoms may take 10 years or longer to appear after infection. Persons with ARC may be severely debilitated, or they may feel well enough to participate fully in daily activities. Approximately 60% of HIV infected persons will eventually develop symptoms of HIV infection of the brain and nervous system. This can include personality changes and the loss of memory, thinking ability, and the ability to walk.

Transmission of the virus that causes AIDS is limited to certain types of contact with blood, semen, or vaginal secretions. The HIV virus must directly enter the bloodstream of an individual for infection to occur. The virus is spread in three ways.

The first is by sexual intercourse (anal or vaginal) with an infected person.

The second is through blood to blood contact with infected blood. This most commonly occurs during intravenous drug use when paraphernalia contaminated with infected blood are shared. It may also occur when a health care, emergency service or public safety worker is inadvertently cut or punctured with a sharp instrument infected by blood. Before April 1985, some persons receiving donated blood were infected from units of blood contaminated with the virus. Since that time the vast majority of infected units have been identified by a specific blood test and discarded, making the blood supply quite safe. Many persons with hemophilia (a clotting disorder) were infected because the clotting factor they received was infected with the virus. Clotting factor is tested now for the virus and treated with heat to destroy the virus. No one has ever gotten infected from donating blood because the needles used are sterile.

The third is transmission from an infected mother to her unborn child, either before birth or during delivery.

Although the virus has sometimes been found in low levels in saliva, tears and urine of individuals known to have HIV in their blood, contact with these "body fluids" poses no risk of transmission. To date there have been no reliably verified reports of transmission of HIV by these "fluids" even if they are inoculated directly into the bloodstream (e.g., human bite).

Extensive medical evidence indicates that there is no risk of transmission by close nonsexual or non-blood-to-blood contact with an individual known to be infected with HIV. Studies of two groups - family members of persons with AIDS and health care workers - have failed to demonstrate transmission of HIV by casual (nonsexual, non-needlesharing) contact.

Contact that is insufficient to transmit the virus includes touching the same object handled by an HIV infected individual (e.g., telephones, other office equipment, water fountains, toilets, or eating utensils). Working or living in the same room will not transmit the virus. Eating food prepared by an HIV infected person will not transmit HIV. Neither will touching, hugging or kissing on the cheek or superficial skin contact with the saliva of HIV infected persons transmit the virus to other people.

Because accidental needlestick exposures to HIV contaminated blood can be associated with transmission of the virus, efforts at preventing transmission in the workplace should be focused on minimizing the occurrence of needlesticks or other penetrating injuries with possibly infected material. The actual risk is low. Approximately one needlestick (with an infected needle) in 200 will result in transmission of HIV.

PRINCIPLES

All state agencies should follow these basic principles:

1. No restrictions should be placed on the employment of persons with AIDS, ARC or HIV infection if that individual's health status enables him to perform the duties required by his employment. The State may modify the duties of an employee based on medical recommendations or consistent with managerial prerogatives.

2. There is no scientific or medical justification for testing current or prospective workers for evidence of HIV infection for the purpose of assessing employability.

3. No special precautions are necessary to prevent transmission of HIV in the workplace, except for employees involved in the direct delivery of health care services and for those who might otherwise come in contact with blood. Since it is impossible to know with absolute certainty which people have been infected with HIV, all professionals providing hands-on care (which may entail exposure to blood) should observe the universal blood and body fluids precautions (updated 6/88) recommended by the U.S. Centers for Disease Control (3,4), thereby treating every client as though infected.

4. In compliance with the U.S. Departments of Labor and Health and Human Services Advisory Notice (1), agencies should develop specific guidelines and protocols, as necessary, for employees delivering health care and handling blood. Such protocols should be readily available to the employees. The AIDS Section, Department of Health Services, should be called upon for assistance in developing these guidelines and protocols.

SPECIFIC AIDS-RELATED GUIDELINES FOR STATE EMPLOYEES

Attached are recommendations for the handling of blood and body fluids (Appendix A). Recommendations for prevention of transmission of HIV for health-care workers, including pre-hospital emergency health-care providers, may be found in Appendix B. If there are any questions regarding these guidelines or if help is desired in refining them for individual departments, please contact the AIDS Section of the Department of Health Services at 566-1157. Copies of the United States Public Health Service Centers for Disease Control recommendations, from which these guidelines were drawn, can be obtained by calling the same number. Please call the Epidemiology Section, CT Department of Health Services for questions about infectious diseases in the workplace other than HIV.

APPENDIX A

Preventing Transmission of Infectious Agents: General Recommendations for the Handling of Blood and Body Fluids

The following guidelines are meant to provide simple and effective precautions against transmission of disease for all persons, including pregnant women, potentially exposed to any blood or body fluids.

Does Contact With Body Fluids Present a Risk?

The body fluids of all persons should be considered to contain potentially infectious agents (germs). The term "body fluids" includes: blood, semen, drainage from scrapes and cuts, feces, urine, vomitus, respiratory secretions (e.g., nasal discharge) and saliva. Contact with body fluids presents a risk of infection with a variety of germs. In general, however, the risk is very low and dependent on a variety of factors including the type of fluid with which contact is made and the type of contact made with it.
Table 1 provides examples of particular germs that may occur in body fluids and the respective transmission concerns. It must be emphasized that with the exception of blood, urine and semen, which are normally sterile, the body fluids with which one may come in contact usually contain many organisms, some of which may cause disease. HIV infection can only be transmitted by blood, semen or vaginal secretions. These are the only vehicles of transmission. There is no well documented scientific evidence for HIV transmission by any other body fluid. Transmission of HIV occurs when direct blood-to-blood, semen to blood or vaginal secretions to blood contact. Such contact is more likely if the HIV infected blood, semen or vaginal secretions contact broken skin or mucous membranes. Furthermore, many germs may be carried by persons who have no symptoms of illness. These individuals may be at various stages of infection: incubating disease, mildly infected without symptoms, or chronic carriers of certain infectious agents including the AIDS and hepatitis viruses. In fact, transmission of communicable diseases is more likely to occur from contact with the infected body fluids of unrecognized carriers than from contact with fluids from recognized individuals because these simple precautions are not carried out.

What Should Be Done to Avoid Contact With Body Fluids?

When possible, direct skin contact with body fluids should be avoided. Disposable gloves should be available where body fluids can be expected to be routinely encountered. Gloves are recommended when direct hand contact with body fluids is anticipated. Gloves used for this purpose should be put in a plastic bag or lined trash can, secured, and disposed of daily.

What Should Be Done if Direct Skin Contact Occurs?

In many instances, unanticipated skin contact with body fluids may occur in situations where gloves may not be immediately available (e.g., when wiping a runny nose, applying pressure to bleeding injury, helping a person in the bathroom). In these instances, hands and other affected skin areas of all exposed persons should be routinely washed with soap and water after direct contact has ceased. Clothing and other nondisposable items (e.g., towels used to wipe up body fluid) that are soaked through with body fluids should be rinsed and placed in plastic bags for transport to the laundry. If presoaking is required to remove stains (e.g., blood, feces), use gloves to rinse or soak the item in cold water. Contaminated disposable items (e.g., tissues, paper towels, diapers) should be handled with disposable gloves.

TABLE 1
TRANSMISSION CONCERNS OF INFECTIOUS AGENTS BY BODY FLUID - SOURCE

BODY FLUID-SOURCE	ORGANISM OF CONCERN	TRANSMISSION CONCERN
Blood -cuts/abrasions -nosebleeds -menses -contaminated needle	Hepatitis B virus HIV (AIDS) virus Cytomegalovirus	Blood stream inoculation through cuts and abrasions on hands Direct blood stream inoculation
*Feces -incontinence	Salmonella bacteria Shigella bacteria Rotavirus Hepatitis A virus Giardia	Oral inoculation from contaminated hands
*Respiratory Secretions -saliva -nasal discharge	Mononucleosis virus Common cold virus Influenza virus	Oral inoculation from contaminated hands
Semen	Hepatitis B virus HIV (AIDS) virus Gonorrhea	Sexual contact (intercourse)
*Urine -incontinence	Cytomegalovirus	Bloodstream and oral (?) inoculation from contaminated hands
*Vomitus	Gastrointestinal viruses, e.g., (Norwalk agent Rotavirus)	Oral inoculation from contaminated hands

*Transmission of HIV (AIDS) virus and Hepatitis B virus is not a concern from these sources unless they are visibly contaminated with blood.

How Should Spilled Body Fluids Be Removed from the Environment?

Many agencies have standard procedures already in place for removing body fluids (e.g., vomitus). These procedures should be reviewed to determine whether appropriate cleaning and disinfection steps have been included. Many stock sanitary absorbent agents are specifically intended for cleaning body fluids spills (e.g., ZGOOP, Parsen Mfg. Co., Philadelphia, PA). Disposable gloves should be worn when using these agents. The dry material is applied to the area, left for a few minutes to absorb the fluid, and then vacuumed or swept up. The vacuum bag or sweepings should be disposed of in a plastic bag. Broom and dustpan should be rinsed in a disinfectant. No special handling is required for vacuuming equipment.

Handwashing Procedures

Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 10 seconds. Soap suspends easily removable soil and microorganisms allowing them to be washed off. Running water is necessary to carry away dirt and debris. Rinse under running water. Use paper towels to thoroughly dry hands.

Disinfectants

An intermediate level disinfectant should be used to clean surfaces contaminated with body fluids. Such disinfectants will kill vegetative bacteria, fungi, tubercle bacillus and viruses. The disinfectant should be registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in medical facilities and hospitals.

Various classes of disinfectants are listed below. Hypochlorite solution (bleach) is preferred for objects that may be put in the mouth.

1. Ethyl or isopropyl alcohol (70%)

2. Phenolic germicidal detergent in a 1% aqueous solution (e.g., Lysol*).

3. Sodium Hypochlorite, with at least 100 ppm available chlorine (1/2 cup household bleach in 1 gallon water, needs to be freshly prepared each time it is used).

4. Quaternary ammonium germicidal detergent in 2% aqueous solution (e.g., Tri-quat*, Mytar*, or Sage*).

5. Iodophor germicidal detergent with 500 ppm available iodine (e.g., Wescodyne*).

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* Brand names are used only as examples of each type of germicidal solution and should not be considered an endorsement of a specific product.

Disinfection of Hard Surfaces and Care of Equipment

After removing spilled body fluid, apply a disinfectant. Mops should be soaked in the disinfectant after use and rinsed thoroughly or washed in a hot water cycle before rinse. Non-disposable cleaning equipment (dust pans, buckets) should be thoroughly rinsed in the disinfectant. The disinfectant solution and rinse water should be promptly disposed down a drain pipe. Disposable cleaning equipment should be placed in a plastic bag.
Apply the sanitary absorbent agent, let dry and vacuum. If necessary, mechanically remove the matter with a dust pan and broom, then apply rug shampoo (a germicidal detergent) with a brush and revacuum. Rinse the dust pan and broom in disinfectant. If necessary, wash the brush with soap and water. Dispose of nonreusable cleaning equipment as noted above.

Disinfection of Rugs

If a wet vacuum is used, run 1/2 gallon of a 1:10 dilution of chlorine bleach in water through the machine after use. It is not necessary to dismantle the machine.

Laundry Instructions for Clothing Soiled with Body Fluids

The most important consideration in laundering contaminated clothing is to eliminate potentially infectious agents with soap and water. Addition of bleach will further reduce the number of potentially infectious agents. Clothing soaked with body fluids should be washed separately from other items. Presoaking may be required for heavily soiled clothing. Otherwise, wash and dry as usual. If the material is bleachable, add 1/2 cup household bleach to the wash cycle. If material is not colorfast, add 1/2 cup nonclorox bleach (e.g., Clorox II, Borateem) to the wash cycle.

APPENDIX B

Preventing HIV Transmission: Recommendations for Health Care Workers

Health care workers include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

These recommendations, based on recommendations developed by the U.S. Public Health Service and the Centers for Disease Control (3,4), emphasize precautions appropriate to prevent transmission of bloodborne infectious organisms, including HIV and hepatitis B virus (HBV). These precautions should be routinely enforced, as should other standard infection-control precautions. The risk of transmission of HIV by parenteral exposure to a needle or other sharp instrument contaminated with the blood of an infected patient is 1/200 or 0.5% (5). Yet most of these incidents are preventable and more emphasis must be given to precautions targeted to prevent needlestick injuries in workers caring for any patient. In addition to being informed of these precautions, all health care workers should be educated regarding the epidemiology, modes of transmission, and prevention of HIV infection.

The following precautions represent prudent practices that apply to preventing transmission of HIV and other bloodborne infections by health care workers in the workplace and should be used routinely, regardless of whether the workers or patients are known to be infected with HIV or HBV.

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposely bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

5. Pregnant health care workers are not known to be at greater risk of contracting HIV infections than health care workers who are not pregnant; however, if a worker develops HIV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especiallyfamiliar with precautions for preventing HIV transmission. Pregnant health care workers should be aware that the General Recommendations for the Handling of Blood and Body Fluids (Appendix A) are useful and important precautions to avoid infection with organisms (such as Cytomegalovirus) which can affect the fetus.

Precautions for Home Health Care Workers

Persons infected with HIV can be safely cared for in home environments. Studies of family members of patients infected with HIV have found no evidence of HIV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (6,7). Health care workers providing home care face the same risk of transmission of infection as workers in hospitals and other health care settings if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health care service in the home to persons infected with HIV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposely bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and blood spills should be treated as outlined above in the "General Recommendations for the Policy for Handling of Blood and Body Fluids - Appendix A".

Precautions for Prehospital Emergency Health-Care Workers

Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HIV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for health care workers providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other health care workers. No transmission of HIV infection during mouth-to-mouth resuscitation has been documented. However, because blood is routinely encountered in the oral cavity of patients during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or bloody saliva. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use. If resuscitation equipment is not available, mouth-to-mouth resuscitation must be performed. Lack of equipment is never an acceptable reason to avoid performing cardiopulmonary resuscitation when indicated.

Management of Parenteral and Mucous Membrane Exposures

If a worker has a parenteral (needlestick or cut) exposure, or a mucous membrane (splash to the eye or mouth) exposure to blood, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HIV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HIV infection. If the source patient has AIDS or other evidence of HIV infection, declines testing, or has a positive test, the worker should be evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure, and, if seronegative, retested after six weeks and on a periodic basis thereafter for a six month period to determine if transmission has occurred (5,8,9). During this follow-up period, exposed health care workers should receive counseling about the risk of infection and follow U.S. Public Health Service recommendations for preventing transmission of HIV (10,11).

If the source patient has a negative blood test and has no other evidence of HIV infection, no further follow-up of the health-care worker is usually necessary. However, it must be recognized that infected source patients may take 6 months to seroconvert and their blood is potentially infectious during this "window period." If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

AIDS Policy for State Personnel

APPENDIX C:

Supplement (June 3, 1988)

STATE OF CONNECTICUT
DEPARTMENT OF ADMINISTRATIVE SERVICES
PERSONNEL DIVISION
STATE OFFICE BUILDING HARTFORD, CONNECTICUT 06106-1630

TO: HEADS OF CONNECTICUT STATE AGENCIES
AND
AGENCY PERSONNEL ADMINISTRATORS

FROM: Sandra Biloon Sandra Biloon
Director of Personnel and Labor Relations

DATE: June 3, 1988

SUBJECT: AIDS Policy for State Personnel

This policy supplements the "AIDS Guidelines for State Personnel" issued in January 1987, and existing agency-specific policies. Further background information can be found in these Guidelines which are attached for your convenience.

As part of this policy, an AIDS contact person should be designated in each agency. This person should normally be the Personnel and Labor Relations designee unless the agency head directs otherwise. Any employee or supervisor who needs information or assistance should be directed to this individual, who will coordinate agency and State resources.

Purpose:

The purpose of this policy is to provide guidelines in dealing with work situations involving employees who have, or are perceived to be at risk of acquiring any of the following:

Acquired Immune Deficiency Syndrome (AIDS)
AIDS Related Complex (ARC)
Human Immunodeficiency Virus (HIV-Infection)
or a related condition.

The term "AIDS", as used in this policy, should be understood as encompassing all of the above.

General Statement:

The State recognizes its obligation to provide a safe and healthy work environment for all its employees. In addition, the State is committed to providing fair and nondiscriminatory treatment to all employees. Therefore, it is the policy of the State of Connecticut that individuals with AIDS, ARC, HIV-Infection related conditions will be treated with the same compassion and consideration given to any employee with a health problem.

Employees With AIDS:

An employee who has, or is suspected of having AIDS, has the right to continue working as long as job duties can be performed satisfactorily. Employers should make reasonable accommodations in job assignments when necessary because of an affected employee's medical condition. The agency AIDS contact person should be made aware of any such changes.

All reasonable steps should be taken to protect the identity of an employee with AIDS.

Workplace Concerns:

The most important factor to remember when confronted with concerns about AIDS in the workplace is that, according to the latest information from the U.S. Center for Disease Control, there is no risk of an individual becoming infected with the AIDS virus in normal workplace situations. Thus, employees are expected to perform their normal work duties with co-workers or any other individual they come into contact with who has or may have AIDS. Employees in occupations such as health care workers where there is exposure to blood, should follow the recommendations set out in "AIDS Guidelines for State Personnel," agency-specific policies, and Department of Health Services publications on this topic.

Efforts will be made to provide information about AIDS to all employees. If a concern about AIDS transmission arises in the workplace, the involved employees should be counseled by Department of Health Services employees or other trained personnel. Said counseling should specifically address employee concerns.

Situations may arise where an employee still refuses to perform all or part of a job duty because of fear of exposure to AIDS. Any employee who refuses to carry out normal work assignments should be counseled by their supervisor and/or designated AIDS contact person. Emphasis should be placed on resolving the situation through counseling. In general, the AIDS employee should remain at work during this period. If needed to defuse the situation, employers may prefer to reassign job duties for a period of time.

Managers and supervisors should be sensitive to co-workers concerns about AIDS. However, where it has been determined that there is no health or safety risk, those individuals who feel threatened by a fellow employee's health condition will not be allowed to refuse to work. Employers should consult applicable contract provisions for employees covered by collective bargaining agreements.

The State is confident that through the dissemination of accurate information on AIDS and effective counseling techniques that any workplace problems can be alleviated.

All questions about this policy should be directed to the agency AIDS contact person. As a precaution, issues or questions about workplace safety situations and AIDS should also be addressed by the AIDS section of the Department of Health Services at 566-1157.

SB:VMS

ATTACHMENTS

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APPENDIX D

STATE BOARD OF EDUCATION GUIDELINES

At the January, 1988, meeting of the State Board of Education, the attached policy guidelines were approved. By this action, the State Board of Education reaffirmed and formalized its position on educating students known to have either AIDS or HIV infection.

This policy statement was developed directly from the original Connecticut guidelines, entitled "Administrative Guidelines for Providing Education to Students with AIDS/ARC." These were published in Prevention of Disease Transmission in Schools: Acquired Immune Deficiency Syndrom, State of Connecticut, Department of Education and Department of Health Services, May 1985. A minor revision was made in the language referring to infections related to the AIDS virus. Instead of the phrase, "AIDS Related Complex (ARC)," the policy uses the phrase, "Human Immundeficiency Virus (HIV) infection," the current accepted terminology for the spectrum of infection other than diagnosed AIDS.

STATE OF CONNECTICUT

STATE BOARD OF EDUCATION

TO: Superintendents of Schools
Executive Directors of Regional Educational Service Centers
Headmasters of Incorporated and Endowed Academies

FROM: Lorraine M. Aronson
Deputy Commissioner of Education
for Program and Support Services

Lorraine M. Aronson

DATE: February 5, 1988

SUBJECT: Acquired Immune Deficiency Syndrome: State Board of Education Policy and District Technical Assistance Needs

This memo is to bring you up-to-date on two very important issues related to our efforts to deal with the problem of AIDS:

> The recently adopted State Board of Education policy concerning educating students with AIDS or HIV infection, and
>
> A cooperative effort by the State Department of Education and the state's Regional Educational Service Centers to provide technical assistance in AIDS education.

I. State Policy Concerning the Education of Students with Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Infection

At the January 1988 meeting of the State Board of Education, the attached policy and guidelines were approved. By this action, the State Board of Education has reaffirmed and formalized its position on educating students known to have either AIDS or AIDS virus infection.

This policy statement was developed directly from the original Connecticut guidelines, "Administrative Guidelines for Providing Education to Students with AIDS/ARC," published in Prevention of Disease Transmission in Schools: Acquired Immune Deficiency Syndrome, State of Connecticut, Department of Education and Department of Health Services, May 1985. A minor revision was made in the language referring to infections related to the AIDS virus. Instead of the phrase AIDS Related Complex (ARC), the policy uses the phrase Human Immunodeficiency Virus (HIV) infection, the current accepted terminology for the spectrum of infection other than diagnosed AIDS.

It is our hope that the State Board policy will provide support to local school districts in developing and implementing local policy on this issue.

II. Technical Assistance

As you can no doubt imagine, we at the Department have been inundated with requests from school districts for assistance in dealing with the issue of AIDS in the schools. We are making every attempt to respond quickly to requests for materials, training and presentations, but it has become clear that we will have to organize our response capacity in better ways if we are reasonably to meet demand. The Regional Educational Service Centers have graciously agreed to help us in this task; together, we have agreed upon the following:

1. Our job is to help districts deal with this difficult issue. We will make materials available (such as the resource packet we distributed last year), update information as necessary, and provide training for staff. We will no longer speak to your students, since this is an activity more appropriately undertaken by your own staff. We will, however, continue presentations to staff, board members, municipal officials and others as the situation warrants and time permits.

2. We must maximize the use of our resources - staff time in particular - to accommodate demand. In reviewing our efforts over the past year or so, we noticed that a) we have done repeat presentations in the same district, b) we have done the same activity in neighboring districts, and c) we have responded to requests not just from a district central office, but from individual schools. We will henceforth work with the Regional Educational Service Centers to attempt to organize activities, to the extent possible and appropriate, on a regional (or sub-regional) basis. (We will continue to do district-based activities in large districts.) The RESC Curriculum Directors will be working with Curriculum Councils in this regard.

3. We need to know what you need. To that end, if you are interested in technical assistance in issues related to AIDS, it would be extremely helpful if you could take a few minutes to complete the attached sheet and forward it to the RESC person designated. (Please DO NOT mail this to the Department.)

Finally, please understand that we are learning as we go. In the course of the past couple of years, for example, we have acquired a much better sense of which materials hold student interest. With the help of a grant from the Centers for Disease Control, we will also be undertaking an evaluation of the effectiveness of instructional strategies. We know now, too, that not all staff are willing, able and comfortable in handling this very difficult topic; the task clearly demands a special kind of person. Luckily, the Department has three such persons ready to help you: Elaine Brainerd (School Health Services), Veronica Skerker (Substance Abuse Prevention/Health and Safety Education) and Jane Burgess (AIDS Education). We are very proud of the work they have done and continue to do.

Our thanks to you, and special thanks to RESC staff, for joining us in the fight against AIDS.

STATE BOARD OF EDUCATION

POLICY CONCERNING EDUCATING STUDENTS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME/HUMAN IMMUNODEFICIENCY VIRUS INFECTION

Policy:

All children in Connecticut have a constitutional right to a free, suitable program of educational experiences. Given the manner in which Acquired Immune Deficiency Syndrome (AIDS) and milder immune deficiencies associated with Human Immunodeficiency Virus (HIV) infection (such as AIDS Related Complex) are transmitted, children with either AIDS or HIV infection should not pose a health risk to other children or staff in a school setting.

As a general rule, a child with AIDS/HIV infection should be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges and services provided by law and local policy of each school district. Exceptions to this rule should be made only under special circumstances in which a child with AIDS/HIV infection might pose a risk of transmission to others. Such exceptions should be made on a case-by-case basis, with each case carefully evaluated individually and in accordance with the following guidelines.

Guidelines:

1. The school should respect the right to privacy of the individual; therefore, knowledge that a child has AIDS/HIV infection should be confined to those persons with a direct need to know (e.g. principal, school nurse, child's teacher). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements.

2. Based upon individual circumstances, including those discussed below, special programming may be warranted. Special education should be provided if determined to be necessary by the Planning and Placement Team.

3. Under the following circumstances a child with AIDS/HIV infection might pose a risk of transmission to others: if the child lacks toilet training, has open sores that cannot be covered, or demonstrates behavior (e.g. biting) which could result in direct innoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist, the school medical advisor, in consultation with the school nurse and the child's physician, must determine whether a risk of transmission exists. If it is determined that a risk exists, the student shall be removed from the classroom.

4. A child with AIDS/HIV infection may be temporarily removed from the classroom for the reasons stated in #3 until either an appropriate school program adjustment can be made, an appropriate alternative education program can be established, or the medical advisor determines that the risk has abated and the child can return to the classroom.

   a) A child removed from the classroom for biting or lack of toilet training should be immediately referred to the Planning and Placement Team for assessment and, thereafter, for the development of an appropriate program if warranted.

   b) A child temporarily removed from the classroom for open sores or skin eruptions which cannot be covered should be placed on homebound instruction and readmitted only with medical documentation that the risk no longer exists.

   c) Removal from the classroom under sections a) and b) above should not be construed as the only responses to reduce risk of transmission. The school district should be flexible in its response and attempt to use the least restrictive means to accommodate the child's needs.

   d) In any case of temporary removal of the student from the school setting, state regulations and school policy regarding homebound instruction must apply.

5. Each removal of a child with AIDS/HIV infection from normal school attendance should be reviewed by the school medical advisor in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

6. A child with AIDS/HIV infection, as with any other immunodeficient child, may need to be removed from the classroom for his/her own protection when cases of measles or chicken pox are occurring in the school population. This decision should be made by the child's physician and parent/guardian in consultation with the school nurse and/or the school medical advisor.

7. The school nurse should function as (a) the liaison with the child's physician, (b) the AIDS/HIV infected child's advocate in the school (i.e. assist in problem resolution, answer questions) and (c) the coordinator of services provided by other staff.

8. Routine and standard procedures should be used to clean up after a child has an accident or injury at school. Blood or other body fluids emanating from any child, including ones known to have AIDS/HIV infection, should be treated cautiously. Gloves should be worn when cleaning up blood spills. These spills should be disinfected with either bleach or another disinfectant, and persons coming in contact with them should wash their hands afterwards. Blood soaked items should be placed in leakproof bags for washing or further disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in any child. Handwashing after contact with a school child is routinely recommended only if physical contact has been made with the child's blood or body fluids, including saliva.

January 5, 1988

APPENDIX E

U.S. CENTERS FOR DISEASE CONTROL GUIDELINES

Attached are the U. S. Centers for Disease Control's recommended guidelines for preventing Human Immunodeficiency Virus (HIV) transmission in health care settings.

The first article, "Recommendations for Prevention of HIV Transmission in Health-Care Settings" consolidates and updates all previous recommendations by the U.S. Centers for Disease Control. These guidelines are published in Morbidity and Mortality Weekly Report, August 21, 1987, Volume 36, Number 2S.

The second article, "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health Care Settings," clarifies and supplements the first article above. These guidelines are published in Morbidity and Mortality Weekly Report, June 24, 1988, Volume 37, Number 24.

The U.S. Occupational Safety and Health Administration (OSHA) issued guidelines in August of 1988 addressing the issue of occupational exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV). OSHA identifies the U.S. Centers for Disease Control guidelines above as providing "an appropriate and widely recognized and accepted standard of protection" to be followed by health care employers, and other employers with employees who may come into contact with blood or body fluids in the course of their jobs, in carrying out their responsibilities under the Occupational Safety and Health Act of 1970.

Recommendations for Prevention of HIV Transmission in Health-Care Settings

Introduction

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (*1*) and precautions for health-care workers and allied professionals (*2*); recommendations for preventing HIV transmission in the workplace (*3*) and during invasive procedures (*4*); recommendations for preventing possible transmission of HIV from tears (*5*); and recommendations for providing dialysis treatment for HIV-infected patients (*6*). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (*7*) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (*8*). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons—representing 5.6% of the U.S. labor force—were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (*9*). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had only a convalescent-phase serum sample obtained and tested ≥90 days post-exposure, one—for whom heterosexual transmission could not be ruled out—was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351 with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (*10*). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (*11*). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (*12*).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (*13-15*). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (*16,17*). The other three were health-care workers with non-needlestick exposures to blood from infected patients (*18*). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (*19*).

Precautions To Prevent Transmission of HIV

Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for **all** patients. This approach, previously recommended by CDC (*3,4*), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of **all** patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (*20*).

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for **all** patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC (*7*) for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [*7*]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

Precautions for Invasive Procedures

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.
2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Precautions for Dentistry*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

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*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (*8*).

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

Precautions for Dialysis

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions (*21*). Universal blood and body-fluid precautions should be used when dialyzing **all** patients.

Strategies for disinfecting the dialysis fluid pathways of the hemodialysis machine are targeted to control bacterial contamination and generally consist of using 500-750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30-40 minutes or 1.5%-2.0% formaldehyde overnight. In addition, several chemical germicides formulated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients. The type of dialysis treatment (i.e., hemodialysis or peritoneal dialysis) should be based on the needs of the patient. The dialyzer may be discarded after each use. Alternatively, centers that reuse dialyzers—i.e., a specific single-use dialyzer is issued to a specific patient, removed, cleaned, disinfected, and reused several times on the same patient only—may include HIV-infected patients in the dialyzer-reuse program. An individual dialyzer must never be used on more than one patient.

Precautions for Laboratories[†]

Blood and other body fluids from **all** patients should be considered infective. To supplement the universal blood and body-fluid precautions listed above, the following precautions are recommended for health-care workers in clinical laboratories.

[†] Additional precautions for research and industrial laboratories are addressed elsewhere (*22,23*).

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.
2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.
5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.
6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste (*24*).
8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body-fluid precautions for **all** patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infective.

Environmental Considerations for HIV Transmission

No environmentally mediated mode of HIV transmission has been documented. Nevertheless, the precautions described below should be taken routinely in the care of **all** patients.

Sterilization and Disinfection

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use (*25,26*) in a variety of health-care settings—including hospitals, medical and dental clinics and offices, hemodialysis centers, emergency-care facilities, and long-term nursing-care facilities—are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV (*21,23*).

Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection, a procedure that kills vegetative organisms and viruses but not necessarily large numbers of bacterial spores. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as "sterilants" may be used either for sterilization or for high-level disinfection depending on contact time.

Contact lenses used in trial fittings should be disinfected after each fitting by using a hydrogen peroxide contact lens disinfecting system or, if compatible, with heat (78 C-80 C [172.4 F-176.0 F]) for 10 minutes.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specifications for compatibility of the medical device with chemical germicides be closely followed. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, SW, Washington, D.C. 20460.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice (*27-30*). Embalming fluids are similar to the types of chemical germicides that have been tested and found to completely inactivate HIV. In addition to commercially available chemical germicides, a solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective germicide. Concentrations ranging from approximately 500 ppm (1:100 dilution of household bleach) sodium hypochlorite to 5,000 ppm (1:10 dilution of household bleach) are effective depending on the amount of organic material (e.g., blood, mucus) present on the surface to be cleaned and disinfected. Commercially available chemical germicides may be more compatible with certain medical devices that might be corroded by repeated exposure to sodium hypochlorite, especially to the 1:10 dilution.

Survival of HIV in the Environment

The most extensive study on the survival of HIV after drying involved greatly concentrated HIV samples, i.e., 10 million tissue-culture infectious doses per milliliter (*31*). This concentration is at least 100,000 times greater than that typically found in the blood or serum of patients with HIV infection. HIV was detectable by tissue-culture techniques 1-3 days after drying, but the rate of inactivation was rapid. Studies performed at CDC have also shown that drying HIV causes a rapid (within several hours) 1-2 log (90%-99%) reduction in HIV concentration. In tissue-culture fluid, cell-free HIV could be detected up to 15 days at room temperature, up to 11 days at 37 C (98.6 F), and up to 1 day if the HIV was cell-associated.

When considered in the context of environmental conditions in health-care facilities, these results do not require any changes in currently recommended sterilization, disinfection, or housekeeping strategies. When medical devices are contaminated with blood or other body fluids, existing recommendations include the cleaning of these instruments, followed by disinfection or sterilization, depending on the type of medical device. These protocols assume "worst-case" conditions of extreme virologic and microbiologic contamination, and whether viruses have been inactivated after drying plays no role in formulating these strategies. Consequently, no changes in published procedures for cleaning, disinfecting, or sterilizing need to be made.

Housekeeping

Environmental surfaces such as walls, floors, and other surfaces are not associated with transmission of infections to patients or health-care workers. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary. However, cleaning and removal of soil should be done routinely.

Cleaning schedules and methods vary according to the area of the hospital or institution, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (e.g., bedside tables and hard-surfaced flooring) in patient-care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged. Cleaning of walls, blinds, and curtains is recommended only if they are visibly soiled. Disinfectant fogging is an unsatisfactory method of decontaminating air and surfaces and is not recommended.

Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used. Therefore, cost, safety, and acceptability by housekeepers can be the main criteria for selecting any such registered agent. The manufacturers' instructions for appropriate use should be followed.

Cleaning and Decontaminating Spills of Blood or Other Body Fluids

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body fluids. Strategies for decontaminating spills of blood and other body fluids in a patient-care setting are different than for spills of cultures or other materials in clinical, public health, or research laboratories. In patient-care areas, visible material should first be removed and then the area should be decontaminated. With large spills of cultured or concentrated infectious agents in the laboratory, the contaminated area should be flooded with a liquid germicide before cleaning, then decontaminated with fresh germicidal chemical. In both settings, gloves should be worn during the cleaning and decontaminating procedures.

Laundry

Although soiled linen has been identified as a source of large numbers of certain pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended (*26*). Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in patient-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed with detergent in water at least 71 C (160 F) for 25 minutes. If low-temperature(≤70 C [158 F]) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.

Infective Waste

There is no epidemiologic evidence to suggest that most hospital waste is any more infective than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission. The most practical approach to the management of infective waste is to identify those wastes with the potential for causing infection during handling and disposal and for which some special precautions appear prudent. Hospital wastes for which special precautions appear prudent include microbiology laboratory waste, pathology waste, and blood specimens or blood products. While any item that has had contact with blood, exudates, or secretions may be potentially infective, it is not usually considered practical or necessary to treat all such waste as infective (*23,26*). Infective waste, in general, should either be incinerated or should be autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer.

Implementation of Recommended Precautions

Employers of health-care workers should ensure that policies exist for:

1. Initial orientation and continuing education and training of all health-care workers—including students and trainees—on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal blood and body-fluid precautions for all patients.
2. Provision of equipment and supplies necessary to minimize the risk of infection with HIV and other blood-borne pathogens.
3. Monitoring adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, counseling, education, and/or re-training should be provided, and, if necessary, appropriate disciplinary action should be considered.

Professional associations and labor organizations, through continuing education efforts, should emphasize the need for health-care workers to follow recommended precautions.

Serologic Testing for HIV Infection

Background

A person is identified as infected with HIV when a sequence of tests, starting with repeated enzyme immunoassays (EIA) and including a Western blot or similar, more specific assay, are repeatedly reactive. Persons infected with HIV usually develop antibody against the virus within 6-12 weeks after infection.

The sensitivity of the currently licensed EIA tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for ≥12 weeks. Optimal laboratory conditions include the use of reliable reagents, provision of continuing education of personnel, quality control of procedures, and participation in performance-evaluation programs. Given this performance, the probability of a false-negative test is remote except during the first several weeks after infection, before detectable antibody is present. The proportion of infected persons with a false-negative test attributed to absence of antibody in the early stages of infection is dependent on both the incidence and prevalence of HIV infection in a population (Table 1).

The specificity of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of initially reactive specimens by EIA is required to reduce the likelihood of laboratory error. To increase further the specificity of serologic tests, laboratories must use a supplemental test, most often the Western blot, to validate repeatedly reactive EIA results. Under optimal laboratory conditions, the sensitivity of the Western blot test is comparable to or greater than that of a repeatedly reactive EIA, and the Western blot is highly specific when strict criteria are used to interpret the test results. The testing sequence of a repeatedly reactive EIA and a positive Western blot test is highly predictive of HIV infection, even in a population with a low prevalence of infection (Table 2). If the Western blot test result is indeterminant, the testing sequence is considered equivocal for HIV infection.

TABLE 1. Estimated annual number of patients infected with HIV not detected by HIV-antibody testing in a hypothetical hospital with 10,000 admissions/year*

Beginning prevalence of HIV infection	Annual incidence of HIV infection	Approximate number of HIV-infected patients	Approximate number of HIV-infected patients not detected
5.0%	1.0%	550	17-18
5.0%	0.5%	525	11-12
1.0%	0.2%	110	3-4
1.0%	0.1%	105	2-3
0.1%	0.02%	11	0-1
0.1%	0.01%	11	0-1

*The estimates are based on the following assumptions: 1) the sensitivity of the screening test is 99% (i.e., 99% of HIV-infected persons with antibody will be detected); 2) persons infected with HIV will not develop detectable antibody (seroconvert) until 6 weeks (1.5 months) after infection; 3) new infections occur at an equal rate throughout the year; 4) calculations of the number of HIV-infected persons in the patient population are based on the mid-year prevalence, which is the beginning prevalence plus half the annual incidence of infections.

When this occurs, the Western blot test should be repeated on the same serum sample, and, if still indeterminant, the testing sequence should be repeated on a sample collected 3-6 months later. Use of other supplemental tests may aid in interpreting of results on samples that are persistently indeterminant by Western blot.

Testing of Patients

Previous CDC recommendations have emphasized the value of HIV serologic testing of patients for: 1) management of parenteral or mucous-membrane exposures of health-care workers, 2) patient diagnosis and management, and 3) counseling and serologic testing to prevent and control HIV transmission in the community. In addition, more recent recommendations have stated that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at highest risk of infection (*32*).

Adherence to universal blood and body-fluid precautions recommended for the care of all patients will minimize the risk of transmission of HIV and other blood-borne pathogens from patients to health-care workers. The utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. Results of such testing may not be available in emergency or outpatient settings. In addition, some recently infected patients will not have detectable antibody to HIV (Table 1).

Personnel in some hospitals have advocated serologic testing of patients in settings in which exposure of health-care workers to large amounts of patients' blood may be anticipated. Specific patients for whom serologic testing has been advocated include those undergoing major operative procedures and those undergoing treatment in critical-care units, especially if they have conditions involving uncontrolled bleeding. Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions. In addition, when deemed appropriate, testing of individual patients may be performed on agreement between the patient and the physician providing care.

In addition to the universal precautions recommended for all patients, certain additional precautions for the care of HIV-infected patients undergoing major surgical operations have been proposed by personnel in some hospitals. For example, surgical procedures on an HIV-infected patient might be altered so that hand-to-hand passing of sharp instruments would be eliminated; stapling instruments rather than

TABLE 2. Predictive value of positive HIV-antibody tests in hypothetical populations with different prevalences of infection

	Prevalence of infection	Predictive value of positive test[*]
Repeatedly reactive enzyme immunoassay (EIA)[†]	0.2%	28.41%
	2.0%	80.16%
	20.0%	98.02%
Repeatedly reactive EIA followed by positive Western blot (WB)[§]	0.2%	99.75%
	2.0%	99.97%
	20.0%	99.99%

[*] Proportion of persons with positive test results who are actually infected with HIV.
[†] Assumes EIA sensitivity of 99.0% and specificity of 99.5%.
[§] Assumes WB sensitivity of 99.0% and specificity of 99.9%.

hand-suturing equipment might be used to perform tissue approximation; electrocautery devices rather than scalpels might be used as cutting instruments; and, even though uncomfortable, gowns that totally prevent seepage of blood onto the skin of members of the operative team might be worn. While such modifications might further minimize the risk of HIV infection for members of the operative team, some of these techniques could result in prolongation of operative time and could potentially have an adverse effect on the patient.

Testing programs, if developed, should include the following principles:

- Obtaining consent for testing.
- Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
- Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
- Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
- Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.

Testing of Health Care Workers

Although transmission of HIV from infected health-care workers to patients has not been reported, transmission during invasive procedures remains a possibility. Transmission of hepatitis B virus (HBV) – a blood-borne agent with a considerably greater potential for nosocomial spread – from health-care workers to patients has been documented. Such transmission has occurred in situations (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (*33,34*).

The hepatitis B experience indicates that only those health-care workers who perform certain types of invasive procedures have transmitted HBV to patients. Adherence to recommendations in this document will minimize the risk of transmission of HIV and other blood-borne pathogens from health-care workers to patients during invasive procedures. Since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed. If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results – as previously outlined for testing programs for patients – must be addressed.

Management of Infected Health-Care Workers

Health-care workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., measles, varicella). Any health-care worker with an impaired immune system should be counseled about the potential risk associated with taking care of patients with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (*7,35*). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating health-care workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV – especially those who perform invasive procedures – can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Management of Exposures

If a health-care worker has a parenteral (e.g., needlestick or cut) or mucous-membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood – especially when the exposed skin is chapped, abraded, or afflicted with dermatitis – the source patient should be informed of the incident and tested for serologic evidence of HIV infection after consent is obtained. Policies should be developed for testing source patients in situations in which consent cannot be obtained (e.g., an unconscious patient).

If the source patient has AIDS, is positive for HIV antibody, or refuses the test, the health-care worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. The health-care worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness – particularly one characterized by fever, rash, or lymphadenopathy – may be indicative of recent HIV infection. Seronegative health-care workers should be retested 6 weeks post-exposure and on a periodic basis thereafter (e.g., 12 weeks and 6 months after exposure) to determine whether transmission has occurred. During this follow-up period – especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert – exposed health-care workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (*36,37*).

No further follow-up of a health-care worker exposed to infection as described above is necessary if the source patient is seronegative unless the source patient is at high risk of HIV infection. In the latter case, a subsequent specimen (e.g., 12 weeks following exposure) may be obtained from the health-care worker for antibody testing. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

If a patient has a parenteral or mucous-membrane exposure to blood or other body fluid of a health-care worker, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source health-care worker and the exposed patient.

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CENTERS FOR DISEASE CONTROL

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Perspectives in Disease Prevention and Health Promotion

Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings

Introduction

The purpose of this report is to clarify and supplement the CDC publication entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*).*

In 1983, CDC published a document entitled "Guideline for Isolation Precautions in Hospitals" (*2*) that contained a section entitled "Blood and Body Fluid Precautions." The recommendations in this section called for blood and body fluid precautions when a patient was known or suspected to be infected with bloodborne pathogens. In August 1987, CDC published a document entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*). In contrast to the 1983 document, the 1987 document recommended that blood and body fluid precautions be consistently used for all patients regardless of their bloodborne infection status. This extension of blood and body fluid precautions to all patients is referred to as "Universal Blood and Body Fluid Precautions" or "Universal Precautions." Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens.

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*The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.

Copies of this report and of the *MMWR* supplement entitled *Recommendations for Prevention of HIV Transmission in Health-Care Settings* published in August 1987 are available through the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

Update: HIV — Continued

Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposures of health-care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood (*3,4*).

Since the recommendations for universal precautions were published in August 1987, CDC and the Food and Drug Administration (FDA) have received requests for clarification of the following issues: 1) body fluids to which universal precautions apply, 2) use of protective barriers, 3) use of gloves for phlebotomy, 4) selection of gloves for use while observing universal precautions, and 5) need for making changes in waste management programs as a result of adopting universal precautions.

Body Fluids to Which Universal Precautions Apply

Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV and HBV to health-care workers by blood is documented (*4,5*). **Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV, and other bloodborne pathogens must focus on preventing exposures to blood as well as on delivery of HBV immunization.**

Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV and HBV, they have not been implicated in occupational transmission from patient to health-care worker. This observation is not unexpected, since exposure to semen in the usual health-care setting is limited, and the routine practice of wearing gloves for performing vaginal examinations protects health-care workers from exposure to potentially infectious vaginal secretions.

Universal precautions also apply to tissues and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk of transmission of HIV and HBV from these fluids is unknown; epidemiologic studies in the health-care and community setting are currently inadequate to assess the potential risk to health-care workers from occupational exposures to them. However, HIV has been isolated from CSF, synovial, and amniotic fluid (*6–8*), and HBsAg has been detected in synovial fluid, amniotic fluid, and peritoneal fluid (*9–11*). One case of HIV transmission was reported after a percutaneous exposure to bloody pleural fluid obtained by needle aspiration (*12*). Whereas aseptic procedures used to obtain these fluids for diagnostic or therapeutic purposes protect health-care workers from skin exposures, they cannot prevent penetrating injuries due to contaminated needles or other sharp instruments.

Body Fluids to Which Universal Precautions Do Not Apply

Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. The risk of transmission of HIV and HBV from these fluids and materials is extremely low or nonexistent. HIV has been isolated and HBsAg has been demonstrated in some of these fluids; however, epidemiologic studies in the health-care and community setting have not implicated these fluids or materials in the transmission of HIV and HBV infections (*13,14*). Some of the above fluids and excretions represent a potential source for nosocomial and community-acquired infections with other pathogens, and recommendations for preventing the transmission of nonbloodborne pathogens have been published (*2*).

Update: HIV — Continued

Precautions for Other Body Fluids in Special Settings

Human breast milk has been implicated in perinatal transmission of HIV, and HBsAg has been found in the milk of mothers infected with HBV (*10,13*). However, occupational exposure to human breast milk has not been implicated in the transmission of HIV nor HBV infection to health-care workers. Moreover, the health-care worker will not have the same type of intensive exposure to breast milk as the nursing neonate. Whereas universal precautions do not apply to human breast milk, gloves may be worn by health-care workers in situations where exposures to breast milk might be frequent, for example, in breast milk banking.

Saliva of some persons infected with HBV has been shown to contain HBV-DNA at concentrations 1/1,000 to 1/10,000 of that found in the infected person's serum (*15*). HBsAg-positive saliva has been shown to be infectious when injected into experimental animals and in human bite exposures (*16–18*). However, HBsAg-positive saliva has not been shown to be infectious when applied to oral mucous membranes in experimental primate studies (*18*) or through contamination of musical instruments or cardiopulmonary resuscitation dummies used by HBV carriers (*19,20*). Epidemiologic studies of nonsexual household contacts of HIV-infected patients, including several small series in which HIV transmission failed to occur after bites or after percutaneous inoculation or contamination of cuts and open wounds with saliva from HIV-infected patients, suggest that the potential for salivary transmission of HIV is remote (*5,13,14,21,22*). One case report from Germany has suggested the possibility of transmission of HIV in a household setting from an infected child to a sibling through a human bite (*23*). The bite did not break the skin or result in bleeding. Since the date of seroconversion to HIV was not known for either child in this case, evidence for the role of saliva in the transmission of virus is unclear (*23*). Another case report suggested the possibility of transmission of HIV from husband to wife by contact with saliva during kissing (*24*). However, follow-up studies did not confirm HIV infection in the wife (*21*).

Universal precautions do not apply to saliva. General infection control practices already in existence — including the use of gloves for digital examination of mucous membranes and endotracheal suctioning, and handwashing after exposure to saliva — should further minimize the minute risk, if any, for salivary transmission of HIV and HBV (*1,25*). Gloves need not be worn when feeding patients and when wiping saliva from skin.

Special precautions, however, are recommended for dentistry (*1*). Occupationally acquired infection with HBV in dental workers has been documented (*4*), and two possible cases of occupationally acquired HIV infection involving dentists have been reported (*5,26*). During dental procedures, contamination of saliva with blood is predictable, trauma to health-care workers' hands is common, and blood spattering may occur. Infection control precautions for dentistry minimize the potential for nonintact skin and mucous membrane contact of dental health-care workers to blood-contaminated saliva of patients. In addition, the use of gloves for oral examinations and treatment in the dental setting may also protect the patient's oral mucous membranes from exposures to blood, which may occur from breaks in the skin of dental workers' hands.

Use of Protective Barriers

Protective barriers reduce the risk of exposure of the health-care worker's skin or mucous membranes to potentially infective materials. For universal precautions, *Update: HIV – Continued*

protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gloves should reduce the incidence of contamination of hands, but they cannot prevent penetrating injuries due to needles or other sharp instruments. Masks and protective eyewear or face shields should reduce the incidence of contamination of mucous membranes of the mouth, nose, and eyes.

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using gloves to prevent gross microbial contamination of hands (*27*). Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised.

The risk of nosocomial transmission of HIV, HBV, and other bloodborne pathogens can be minimized if health-care workers use the following general guidelines:†

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.
2. Use protective barriers to prevent exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

Glove Use for Phlebotomy

Gloves should reduce the incidence of blood contamination of hands during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments. The likelihood of hand contamination with blood containing HIV, HBV, or other bloodborne pathogens during phlebotomy depends on several factors: 1) the skill and technique of the health-care worker, 2) the frequency with which the health-care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health-care worker who performs more procedures), 3) whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely), and 4) the prevalence of infection with bloodborne pathogens in the patient population. The likelihood of infection after skin exposure to blood containing HIV or HBV will depend on the concentration of virus (viral concentration is much higher for hepatitis B than for HIV), the duration of contact, the presence of skin lesions on the hands of the health-care worker, and – for HBV – the immune status of the health-care worker. Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is certainly much less than the 0.5% risk following percutaneous needlestick exposures (*5*). In universal precautions, *all* blood is assumed to be potentially infective for bloodborne pathogens, but in certain settings (e.g., volunteer blood-donation centers) the prevalence of infection with some bloodborne pathogens (e.g., HIV, HBV) is known to be very low. Some institutions have relaxed recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of bloodborne pathogens is known to be very low.

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†The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.

Institutions that judge that routine gloving for *all* phlebotomies is not necessary should periodically reevaluate their policy. Gloves should always be available to health-care workers who wish to use them for phlebotomy. In addition, the following general guidelines apply:

1. Use gloves for performing phlebotomy when the health-care worker has cuts, scratches, or other breaks in his/her skin.
2. Use gloves in situations where the health-care worker judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative patient.
3. Use gloves for performing finger and/or heel sticks on infants and children.
4. Use gloves when persons are receiving training in phlebotomy.

Selection of Gloves

The Center for Devices and Radiological Health, FDA, has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or nonsterile examination gloves made of vinyl or latex. General purpose utility ("rubber") gloves are also used in the health-care setting, but they are not regulated by FDA since they are not promoted for medical use. There are no reported differences in barrier effectiveness between intact latex and intact vinyl used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed.

The following general guidelines are recommended:

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
3. Change gloves between patient contacts.
4. Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.
5. Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.

Waste Management

Universal precautions are not intended to change waste management programs previously recommended by CDC for health-care settings (*1*). Policies for defining, collecting, storing, decontaminating, and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information

Update: HIV – Continued

regarding waste management regulations in health-care settings may be obtained from state or local health departments or agencies responsible for waste management.

Reported by: Center for Devices and Radiological Health, Food and Drug Administration. Hospital Infections Program, AIDS Program, and Hepatitis Br, Div of Viral Diseases, Center for Infectious Diseases, National Institute for Occupational Safety and Health, CDC.

Editorial Note: Implementation of universal precautions does not eliminate the need for other category- or disease-specific isolation precautions, such as enteric precautions for infectious diarrhea or isolation for pulmonary tuberculosis (*1,2*). In addition to universal precautions, detailed precautions have been developed for the following procedures and/or settings in which prolonged or intensive exposures to blood occur: invasive procedures, dentistry, autopsies or morticians' services, dialysis, and the clinical laboratory. These detailed precautions are found in the August 21, 1987, "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*). In addition, specific precautions have been developed for research laboratories (*28*).

APPENDIX F

REPORT TO THE GENERAL ASSEMBLY

BY P.A. 87-527 AIDS TASK FORCE

On January 15, 1988, the Task Force to Review, Research and Recommend State Policy on AIDS issued its final report to the Connecticut General Assembly, pursuant to Public Act 87-527. Frederick G. Adams, Commissioner of the State of Connecticut Department of Health Services, chaired the Task Force. The title pages and executive summary are attached.

PUBLIC ACT 87-527

REPORT TO THE GENERAL ASSEMBLY

AIDS TASK FORCE

TO REVIEW RESEARCH AND RECOMMEND
STATE POLICY ON
ACQUIRED IMMUNE DEFICIENCY SYNDROME

CHAIRMAN

FREDERICK G. ADAMS, D.D.S, M.P.H.

COMMISSIONER, STATE OF CONNECTICUT DEPARTMENT OF HEALTH SERVICES

JANUARY 15, 1988

FINAL REPORT

of the

TASK FORCE

to

Review Research and Recommend

State Policy

on

AIDS

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EXECUTIVE SUMMARY

AIDS Task Force

To Review Research and Recommend State Policy

on

AIDS

Charge #1. To review existing studies and guidelines from state, federal and private agencies on the HIV infection, including, but not limited to, AIDS and the manner through which the HIV infection can be transmitted.

The Task Force has accepted as the most current and complete science, Transmission of the Human Immunodeficiency Virus by Gerald M. Friedland, M.D., and Robert S. Klein, M.D. as reported in the New England Journal of Medicine (Appendix A). Drs. Friedland and Klein conclude that "the accumulated data strongly support the conclusion that transmission of HIV occurs only through blood, sexual activity and perinatal events".

Charge #2. To assess the magnitude, trends and nature of the AIDS epidemic in the state.

- Connecticut ranks ninth nationally in the total number of AIDS cases reported per million population.
- It is estimated that 12,000-24,000 Connecticut residents are infected with the AIDS virus.
- It is estimated that 10% of Black and Hispanic men aged 20-49 years old, in urban areas, are already infected with HIV.
- Connecticut figures differ from national figures in that there are higher proportions of cases in our drug users (35% vs. 17% nationally), in our children (2.8% vs. 1.5%), and in our minority populations (52% vs. 39% nationally).

Charge #3: To develop a state policy to encourage confidential testing of those at possible risk.

Anonymous and confidential counseling and testing should be available throughout Connecticut.

- Mandatory testing is indicated only as a prerequisite for blood, sperm and organ donations.

- Testing information should only be released with documented written or oral consent of the test subject or legal guardian, with exceptions only when necessary for medical care, indicated by law, and fulfilling a compelling, authorized public health interest.

- Sex and needle sharing partners may be notified.

- Testing should not be a condition of employment.

- Persons with HIV infection should have access to comprehensive, catastrophic and affordable health insurance.

Charge #4: To make recommendations on means to protect the civil rights of persons with HIV infections, including persons perceived to be at risk for HIV infection.

- State statutes concerning physical disability discrimination provide adequate protection for those with or perceived to have HIV infection or HIV seropositivity.

- Employers, health care providers and public accommodations should adopt policies and procedures to provide full and equal access for persons with or perceived to have HIV infection or seropositivity.

- School systems should immediately adopt policies regarding attendance for HIV students and personnel rules for HIV employees.

- The Commission on Human Rights and Opportunities should continue to provide expedited case processing to HIV complaints and adopt rules to provide confidentiality at the hearing stage.

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